EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	:	MDL No. 2804
	:	Case No. 17-md-2804
THIS DOCUMENT RELATES TO: "Case Track Seven"	:	Judge Dan Aaron Polster

Monday, January 9, 2023

HIGHLY CONFIDENTIAL
SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

Remote deposition of PATRICK J. MARSHALEK, M.D., commencing at 10:03 a.m., on the above date, before Carol A. Kirk, Registered Merit Reporter, Certified Shorthand Reporter, and Notary Public.

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R E M O T E A P P E A R A N C E S

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INDEX TO EXAMINATION

INDEX TO EXHIBITS

- - -

P R O C E E D I N G S

- - -

PATRICK J. MARSHALEK, M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. CHALOS:

Q. Okay. Thanks, Doctor, for being here today.

My name is Mark Chalos. I'll be asking you questions.

Your name is pronounced Marshalek?

A. Marshalek.

Q. Marshalek. Okay. I will try to remember that.

So you are here today to testify on behalf of Kroger.

Is that your understanding?

A. Yes.

Q. You've spent a significant part of your professional life treating or otherwise dealing with issues around opioid addiction; is that right?

A. Yes.
Q. Were you born and raised in West Virginia?
A. Yes.
Q. What year were you born?
A. 1978.
Q. Okay. So during -- you were licensed to practice medicine in 2007?
A. Yes.
Q. Okay. Were you born in Morgantown?
A. Yes.
Q. Have you spent your entire adult life in Morgantown?
A. For the most part.
Q. Have you lived anywhere else?
A. Not -- no permanent residence anywhere else.
Q. Okay. Were there times that you lived somewhere else?
A. I lived in Portland, Oregon briefly when I was in the process of transitioning jobs.
Q. When was that?

A. That was February -- February of last year till April of last year.
Q. Were you working in Portland?
A. Yeah. Yes, I took a job there.
Q. What was your job in Portland?
A. I accepted a position as senior medical director for Cascadia Healthcare.
Q. And you did that job for four months?
A. I think. Roughly.
Q. And then you left that job?
A. Yes.
Q. Why did you leave?
A. The job and relocation, for family reasons and other reasons, didn't work out.
Q. Okay. What were the other reasons other than family?
A. It's complicated.
Q. Yeah, I certainly understand that. Can you tell us about that? What was complicated about it?
A. Just relocation in general.
Q. Okay. Did you have the option to continue working at Cascadia Behavioral

Healthcare if you wanted to?

A. Yes.

Q. So it was your decision to leave there?

A. Yes.

Q. Why did you take the job with Cascadia?

A. I was at a point in my career where I was ready -- ready for a change. I felt like I wanted to take some of what -- some of my skillsets, what I learned here, practicing here, and take them somewhere else, and, you know, best case scenario, you know, lend my expertise and also learn, learn from others in a different setting.

Q. Prior to working at Cascadia Healthcare, you were an associate professor at WVU; is that right?

A. Yes.

Q. So you left your job as an associate professor at WVU to take the job at Cascadia Healthcare?

A. Yes.

Q. And you worked at Cascadia

Healthcare for about four months and then returned to be an associate professor at WVU?

A. Correct.

Q. Have you ever lived in Ohio?

A. No.

Q. Have you been to Ohio?

A. Yes.

Q. Have you been to Montgomery County, Ohio ever?

A. No.

Q. Have you ever spoken with anyone who lives in Montgomery County, Ohio?

A. Not that I'm aware of.

Q. Have you ever treated any patient for addiction who lives in Montgomery County, Ohio?

A. Not that I recall.

Q. Have you ever spoken with anyone who works at a Kroger or worked at a Kroger in Montgomery County, Ohio?

A. Not that I'm aware of.

Q. Have you spoken with anyone who works at Kroger in connection with this litigation?

A. Not that I'm aware of.

Q. Opioids have been a big problem in your community in West Virginia, right?

MR. CARDI: Object to form, foundation.

You can answer, Doctor.

A. Opioids -- can you ask the question again. I'm sorry.

Q. Sure.

Opioids have been a big problem in your community in West Virginia, correct?

MR. CARDI: Same objection.

A. I'd want to know how you define "big problem."

Q. Okay. Would you, in your judgment, consider opioids to be a big problem in your community in West Virginia? Let's start with today.

A. Yes.

Q. And that's been true during the entirety of your professional life, right, since you've been licensed in 2007?

MR. CARDI: Object to form, foundation.

A. Opioids have been a problem for that whole period of time?
Q. Yes, sir.
A. I think to a certain extent. It's hard to quantify exactly when and where.
Q. Your professional career has been dedicated to dealing with opioids in one form or another; isn't that right?
MR. CARDI: Form, foundation.
A. Can you ask that again, please.
Q. Sure.
Your professional career has been dedicated to dealing with opioids in one form or another; is that right?
A. I would say part of my career has been.
Q. And that's been true since you were licensed in 2007?
A. Yes.
Q. In 2007, West Virginia had some of its historically highest rates of opioid prescriptions; is that right?
A. I would need to see data surrounding that.

Q. Have you ever looked at data about the number of prescriptions over time in West Virginia?

A. I have reviewed that data in the past.

Q. What do you recall about that?

A. I have difficulty recalling specifics.

Q. Have you ever looked at data regarding the numbers of prescriptions over time in Montgomery County, Ohio?

A. Not that I recall.

Q. You were taught in medical school that pain is the fifth vital sign, right?

A. If I recall correctly.

Q. If you recall correctly, yes, you were taught that pain is the fifth vital sign when you were in medical school?

A. I really -- I don't -- I do not recall specifics regarding the pain management didactics.

Q. Okay. Have you ever worked as a pharmacist?

A. No.

Q. Have you ever supervised a pharmacist?

A. Can you define "supervised"?

Q. That's a great question. Can I define "supervise."

Okay. Have you ever worked in a pharmacy?

A. I volunteered in a pharmacy previously.

Q. When was that?

A. I was in medical school. At the free clinic in town.

Q. And what was your role as a volunteer in the pharmacy?

A. Roughly -- just roughly preparing, packaging medications up, putting them in bags.

Q. How long did you do that for?

A. I can't recall exactly how long.

Q. Was it more than one day?

A. Yes. It was over the course of probably a year or two.

Q. And how often would you do that during that year or two?

A. It was roughly a weekly basis.

Q. So once a week, you'd go work in the pharmacy?
A. If I recall correctly.
Q. Okay. And for how long at a time? Would you work for an entire day or a couple hours?
A. If I recall correctly, half days or so.
Q. Did you dispense the medication to patients when you volunteered at the community pharmacy?
A. Not that I recall.
Q. Did you package at any time opioid medications?
A. No.
Q. Okay. So let's go back to my question.
Have you ever had a pharmacist who reported to you in a professional capacity as an employee?
A. Can you ask that one more time?
Q. Sure.
Have you ever had, in a professional capacity, a pharmacist report to

you as an employee of yours?

A. I work in multiple different settings for a large health system. So I wouldn't employ a pharmacist, but I work on teams where pharmacists -- pharmacists are on some of the teams that I work on.

Q. Okay. Have you ever been the boss of a pharmacist?

A. How would you define "boss"?

Q. Well, do you have a boss now?

A. Boss. I think I have probably several.

Q. Do you know who they are?

A. Yes.

Q. Okay. Are you the boss of anybody right now yourself, professionally?

A. I guess it depends on how you kind of utilize that term. Either from an administrative capacity as a medical director or a team leader in clinical settings, I would view myself as kind of the leader of a team.

Q. Have you ever had any role in setting policies for dispensing at a pharmacy?

A. Not that I'm aware of.

Q. Are you familiar with the obligations that pharmacies have before dispensing opioids?

A. Ask that again. I'm sorry.

Q. Sure.

Are you familiar with the obligations that pharmacies have before dispensing opioids?

A. No. But as a clinician with prescriptive authority, I interface with pharmacists and pharmacies on a regular basis.

Q. Are you familiar with any policies or procedures that Kroger has used at any time regarding dispensing opioids?

A. Not that I'm aware of.

Q. Have you ever heard the term "corresponding responsibility" in the context of pharmacies?

A. Not that I'm aware of.

Q. Do you know what the term "corresponding responsibility" means in the context of pharmacies and dispensing opioids?

A. I'm sorry. I want to make sure I'm understanding the last part of that question

correctly.

Q. Sure. And let me ask it a different way.

In the context of pharmacies dispensing opioids, do you know what the term "corresponding responsibility" means?

A. Not that I'm aware of.

Q. Do you agree that pharmacies are the last line of defense against illegitimate prescriptions for opioids being dispensed?

MR. CARDI: Form, foundation.

A. I want to make sure I understand what you mean by "last line of defense."

Q. You don't understand the term "last line of defense"?

A. In the context of your question.

Q. Okay. Every opioid prescription that is written for an outpatient must be dispensed by a pharmacy, right?

A. If I recall correctly.

Q. And in the chain of supplying opioids to the public, the last opportunity to determine whether an opioids prescription is legitimate is at the point of dispensing by the

pharmacist.

Do you agree with that?

A. I want to make sure I understand your question.

Q. Okay. Would you like me to repeat the question?

A. If you could, please.

Q. Sure.

In the chain of supplying opioids to the public, the last opportunity to determine whether an opioid prescription is legitimate is at the point of dispensing by the pharmacist.

Do you agree with that?

A. I don't know if I agree with that. I feel that the clinician -- the clinician assessing the patient through an informed consent process determines whether or not the benefits outweigh the risk with respect to that intervention in regular clinical settings.

Q. In your view, does the pharmacist have any responsibility to determine whether an opioids prescription was written for a legitimate medical purpose?

A. And, again, I apologize. I want

to make sure I understood the first part of that question.

Q. Okay. Does the pharmacist have any responsibility to determine whether an opioids prescription was written for a legitimate medical purpose?

A. Again, I'm not sure if I agree with that, for reasons I stated previously.

Q. Okay. Can you restate those reasons? I'm not sure I caught them.

A. So in a -- has that been -- was my prior statement recorded? I want to make sure -- I just would refer back to that. If not --

Q. It was. Everything you said today is being typed by the court reporter, Ms. Kirk.

So let me ask it again and see if we can get to the bottom of this.

In your view, does the pharmacist -- prior to dispensing an opioids prescription, does a pharmacist have any obligation to determine whether the prescription for opioids was written for a legitimate medical purpose?

MR. CARDI: Objection; asked and answered.

A. Again, I just would -- I think in a clinical setting, the provider with prescriptive authority is the one assessing the patient, determining the need and if the benefits outweigh the risk. In that situation, that's routine clinical practice. It's that shared decision-making between the clinician and the patient.

Q. Does the pharmacist have any obligation -- before dispensing the opioids prescription that was written for the patient, does the pharmacist have any obligation to determine whether the prescription was written for a legitimate medical purpose?

A. I don't know how the pharmacist could since they weren't in the office and did not have the information that the provider with prescriptive authority had, and ...

Q. Okay. I think I understand.

So in your view, the pharmacist has no responsibility to determine whether an opioids prescription was written for a

legitimate medical purpose; is that fair?

MR. CARDI: Objection; asked and answered.

A. I'm not -- like I said before, I don't think that the pharmacist was in the doctor's office and has any ability to determine, didn't play a role in the assessing or informed consent process that led to that recommendation.

Q. Does the pharmacist -- when we're talking about opioids prescriptions, does the pharmacist have to do anything at all to determine whether the prescription was written for a legitimate medical purpose before the pharmacist fills the prescription?

MR. CARDI: Objection; asked and answered.

A. I'm sorry. I want to make sure I understand that question.

Q. Would you like me to repeat the question?

A. Please. Thank you.

Q. Before the pharmacist fills a prescription for opioids, does the pharmacist

have any obligation to determine whether that prescription was written for a legitimate medical purpose?

MR. CARDI: Objection; asked and answered.

A. I'm not a pharmacist, but I'm a clinician, and that's the setting where the recommendations sprang forth. The pharmacist wasn't present there and is ...

Q. So the pharmacist has no obligation to determine whether the prescription was written for a legitimate medical purpose?

MR. CARDI: Objection; asked and answered.

A. I'm not a pharmacist, but I'm a clinician, so I understand the obligations with respect to prescriptive authority and assessing of the patient, weighing of the risks and benefits, informed consent, shared decision-making leads to that in legitimate medical practice.

Q. Okay. So do you know one way or another whether a pharmacist has an obligation to determine whether an opioids prescription was

written for a legitimate medical purpose before the pharmacist fills the prescription?

A. Can you repeat that, please.

Q. Sure.

Do you know one way or another -- and if you don't know, that's fine.

But do you know one way or another whether a pharmacist has an obligation before filling an opioid prescription to determine whether that prescription was written for a legitimate medical purpose?

A. As a clinician, I'm unable to look -- I'm unable to assess whether a script was written legitimately or not. I'm not trained as a pharmacist. I'm not exactly sure how they would be able to either.

Oftentimes we do not realize that it was written for other than legitimate purposes until well after the fact. That's in my practice. Once the provider is in the news or a clinic is shut down, that's oftentimes when we realize it was not legitimate, and it's far too late.

Q. Okay. So -- and I appreciate --

I understand you're trying to answer my question. We may be just missing each other on this. But what I'm asking at first is a yes or no question. You can take all the time you'd like to explain your answer.

But my question to you, sir, is, do you know one way or another whether a pharmacist has an obligation to determine whether an opioid prescription was written for a legitimate medical purpose before the pharmacist fills a prescription?

MR. CARDI: Objection; asked and answered.

Mark, is the confusion here we're talking about legal obligations? I mean --

MR. CHALOS: Listen, I don't know what the confusion is here, frankly. I'm just asking -- I asked first does the pharmacist have an obligation, and I don't think I got a yes or no answer to that.

And now I'm asking if he knows whether the pharmacist has an

obligation. I'm not getting a yes or no answer to that either.

So I don't know what the confusion is. So I'm going to try it again.

BY MR. CHALOS:

Q. I apologize. I know this is tedious, Doctor, and I don't mean it to be.

Do you know, as you sit here today -- I understand you're a clinician.

Do you know, as you sit here today, whether a pharmacist has an obligation under industry standards, medical practice standards, pharmaceutical standards, the law, the federal law, state law, under any law, does the pharmacist have any obligation before filling an opioids prescription to determine whether that prescription was written for a legitimate medical purpose?

A. I just don't know. I, as a clinician, cannot determine that, and I don't know how a pharmacist could either.

Q. Okay. Have you heard the term "red flags" in the context of a pharmacist dispensing opioids?

A. Not that I recall.

Q. Okay. Have you heard the term "due diligence" in the context of a pharmacist dispensing opioids?

A. Not that I can recall.

Q. Do you have any information about what Kroger did to ensure it was meeting any obligations it or its pharmacists might have prior to dispensing opioids in Montgomery County?

MR. CARDI: Objection; asked and answered.

A. Can you repeat that. I'm sorry.

Q. Sure.

Do you have any information at all about what Kroger did to ensure it was meeting any obligations that it or its pharmacists might have had prior to dispensing opioids in Montgomery County?

A. Not that I'm aware of.

Q. Have you -- and I may have asked this, and if I have, I apologize.

Have you reviewed any documents related to any Kroger policies or procedures

regarding the dispensing of opioids?

MR. CARDI: Objection; asked and answered.

A. Not that I'm aware of.

Q. Are you aware of any policies or procedures that Kroger had at any time to alert its pharmacists about suspicious prescribers?

MR. CARDI: Objection; asked and answered.

A. Not that I'm aware of.

Q. Are you aware of any policies or procedures that Kroger had at any time to alert its pharmacists about suspicious patients?

MR. CARDI: Objection; asked and answered.

A. Not that I'm aware of.

Q. Are you aware of any obligation on pharmacies and pharmacists to document due diligence conducted prior to filling any opioids prescriptions in writing?

MR. CARDI: Objection; asked and answered.

A. Not that I'm aware of.

Q. Let me ask that question again,

because I think I may have misspoken.

Are you aware of any obligation on pharmacies or pharmacists to document in writing any due diligence that the pharmacist conducted prior to filling any opioids prescription?

A. Not that I'm aware of.

Q. Have you ever worked for the DEA?

A. I believe I have.

Q. In what capacity?

A. As a consultant.

Q. Can you tell me more about that.

A. Initially I would be contacted by investigators if they were investigating cases attempting to determine legitimacy of clinical practices surrounding controlled substances.

Q. Was your work in connection with criminal prosecutions?

A. At times, it was.

Q. At times was it in connection with civil prosecutions?

A. No.

Q. Okay. Were there -- did you do work for the DEA other than in connection with criminal prosecutions?

A. I was not -- as mentioned earlier, they would seek my input regarding clinical practices and/or prescribers in clinic settings.

In the cases where it appeared there were not legitimate prescriptions, that would advance forward to trial, and had before.

Other times my reports back to them would be that that's standard practice and appeared to be legitimate, and it would not advance forward.

Q. I see.

On how many occasions did you -- were you contacted by the DEA?

A. I can't recall the exact number of times.

Q. Can you give me a ballpark?

A. Honestly, I have trouble -- I'm sorry. I can't tell you the exact amount of times. It's based on kind of the time spread and the nature and extent of the cases.

Q. Okay. Over -- when was the first time you were contacted by the DEA?

A. I don't recall the exact date.

Q. Can you give me a ballpark on the

time frame? Were you -- well, let me ask you this way: Were you licensed to practice medicine the first time that the DEA contacted you?

A. Yes. It was -- it was all after at least 2010.

Q. Okay. When was the last time you were contacted by the DEA?

A. Sometime in 2020 or 2021.

Q. Would it happen roughly once a year? Is that a fair estimate?

A. I do not recall the exact amount of time or the frequency. I'm sorry.

Q. Okay. All right. And we'll go through your resumé and your prior testimony. That might help jog your memory some.

Have you ever had any discussions with anyone at the DEA or any other federal agency about opioids manufacturing quotas?

A. Not that I recall.

Q. Do you know how the DEA or any other federal agency set manufacturing quotas for opioids?

A. Not that I can recall.

Q. Do you know how the federal government decided how opioids would be scheduled?

A. Can you repeat that? I'm sorry.

Q. Sure.

Do you know how the federal government decided how opioids would be scheduled?

A. I can't recall the specifics regarding that.

Q. Have you spoken with anyone at the federal government about how it decides how opioids would be scheduled?

A. Not that I can recall.

Q. Do you know how the FDA decides which indications to approve for opioid medications?

A. I'm sorry. You mentioned FDA. Could you repeat that again. I want to make sure.

Q. Sure.

Do you know how the FDA decides which indications to approve for opioid medications?

A. I don't recall the specifics of that process.

Q. Okay. What do you recall in general?

A. Regarding?

Q. The process by which the FDA decides which indications to approve for opioid medications.

A. Just I only know the -- just kind of -- I'm sorry. I want to make sure I'm answering that correctly, because I don't recall the specifics of how -- how that unfolds.

Q. Okay. What do you recall about how the FDA decides which indications to approve for opioid medications?

A. I recall just vague -- what I do recall are just the phases of trials that medications need to pass through before they're at market and have indications, and that's rough and vague.

Q. Okay. Do you recall or do you know anything more specific than that, about the FDA process?

A. Not that I can recall at this

moment.

Q. Do you have any opinions, as you sit here today, about which indications any particular opioids should have had?

MR. CARDI: Object to form, foundation.

A. Not that I can recall at this moment.

Q. Okay. And as you sit here today, do you have any opinions about what quotas for manufacturing opioids DEA should have set at any time?

MR. CARDI: Objection; form, foundation.

A. Not that I can recall at this moment.

Q. Are you an epidemiologist?

A. No. But my education, training, clinical practice entails understanding and knowledge of that topic.

Q. Do you consider yourself an epidemiologist?

MR. CARDI: Objection; asked and answered.

A. No. But my education, training, and clinical experience entails knowledge and understanding of topics in that field.

Q. Have you heard the term "risk factor"?

A. I've heard that term before.

Q. What does that mean in the context of epidemiology?

A. What does "risk factor" mean? That's a rather vague term.

Q. Okay. You've had some exposure to epidemiology in the course of your medical education, right?

A. Yes.

Q. Okay. Do you know in the context of epidemiology what the term "risk factor" means?

A. I know what it can mean.

Q. Okay. What can it mean?

A. It's a rather nonspecific term. That's why I was hoping to get a little bit of understanding of the context. In its simplest form, it implies risk, something -- a factor that carries risk.

Q. What are the risk factors for opioid use disorder?

A. That's a really difficult question to answer.

Q. Can you give it your best shot?

A. I think to answer that question, you would need to have an understanding of -- if I understand your question correctly, what puts somebody at risk for addiction and/or substance use disorders in general.

And I feel like we're still, as a scientific field, working to gain a deeper understanding of that, this rather complex illness.

Q. Do you treat patients for opioid use disorder?

A. Yes.

Q. Do you treat patients for substance use disorder?

A. Yes.

Q. Do you know what the risk factors are for substance use disorder?

A. Do I know what the risks are for substance use disorder? Is that the question?

Q. Do you know what the risks -- let me ask it a different way.

Do you know what any risk factors are for substance use disorder?

A. One of the risks that I teach on is adverse childhood experiences or traumatic experiences.

Q. Can you think of any other risk factors for substance use disorder?

A. Again, I want to know how we're defining risks.

Q. However you define risk factors in the context of epidemiology and diagnosing substance use disorder is fine for the purposes of this question.

A. Then I think the adverse childhood experiences are something that I mentioned.

Q. Okay. Can you think of any other risk factors for substance use disorder?

A. I can't recall at this moment.

Q. Okay. Let's talk about opioid use disorder.

Can you think of any risk factors for opioid use disorder?

A. I would want to answer the same.
Q. A risk factor for opioid use disorder is adverse childhood experiences?
A. Yes.
Q. Can you think of any other risk factors for opioid use disorder?
A. Not that I can recall at this time.
Q. Do you treat patients for opioid use disorder who use illicit opioids such as heroin and fentanyl?
A. Yes.
Q. Do you ask them how they got started on opioids as part of your practice?
A. Yes.
Q. Have you ever treated a patient for opioid use disorder who uses heroin or fentanyl whose first exposure to opioids was through prescription opioids?
A. I just want to make sure I understand that. If you could repeat it. Thank you.
Q. Sure.
Of the patients that you treat for

opioid use disorder who use heroin or fentanyl, have any of those patients had their first exposure to opioids through prescription opioids?

A. Yes. Some have.

Q. Do you have a ballpark in terms of percentage of the patients that you treat for opioids use disorder who use illicit drugs like heroin or fentanyl who started using opioids initially as prescription opioids?

MR. CARDI: Object to form, foundation.

A. Not that I can recall.

Q. Have you reviewed Dr. Katherine Keyes' report in the Montgomery County litigation?

A. Not that I can recall.

Q. Do you have, as you sit here today, any opinions or criticisms about Dr. Keyes' report in the Montgomery County litigation?

A. I'm sorry. Can you repeat that.

Q. Sure.

As you sit here today, do you have

any criticisms or other opinions about Dr. Keyes' report in the Montgomery County litigation?

A. Not that I can recall.

Q. Do you know who Dr. Katherine Keyes is?

A. I don't recall exactly who she is.

Q. Have you written any articles at any time about the risk factors for opioid use disorder?

A. Not that I can recall.

Q. Have you written any articles about the role of the federal government in regulating the opioids industry?

A. Not that I can recall.

Q. Have you written any articles about the obligations of pharmacies with respect to dispensing opioid prescriptions?

A. Not that I can recall.

Q. Have you ever written or spoken on the obligations of pharmacies with respect to dispensing opioid prescriptions?

A. Not that I can recall.

Q. Have you ever written or spoken on

the risk factors for opioid use disorder in any context?

A. I just -- can you repeat that last question, please.

Q. Sure.

Have you ever written or spoken on the risk factors for opioid use disorder in any context?

A. I don't recall exactly. Sorry.

Q. Okay. Have you written or spoken in any context on the FDA process for determining indications for opioids or any other medications?

A. Not that I can recall.

Q. Have you reviewed any depositions of any DEA or FDA witnesses in the opioids litigation?

A. Not that I can recall.

Q. When were you first contacted to work on this case?

A. I do not recall the exact date or time.

Q. Okay. Can you give us a ballpark on when that was?

A. I'm sorry. I can't recall exactly because -- I just can't.

Q. Your report is dated -- maybe this will help. Your report is dated December 12, 2022.

Does that help give you any context for a ballpark on when you were first contacted about working on this case?

A. It may have been in 2022, if I'm recalling correctly.

Q. Did you write the report in this case?

A. Yes. I wrote that report.

Q. How long did that take you, about?

A. I can't recall exactly how long it took me to prepare and write it.

Q. Did you log your time in some way or write down your time to keep track of it?

A. Yes.

Q. Is that reflected in the invoice that you sent in this case?

MR. CARDI: Object to form, foundation.

A. I prepared an invoice.

Q. Okay. I've only seen one invoice. Well, it's three invoices to three different companies, but it's only for one time period. Does that sound right? And we'll take a look at it. But just from your memory, does that sound right?

A. I think.

Q. Who contacted you to work in this case?

A. I cannot recall the initial point of contact.

Q. Was it someone from a law firm?

A. I do not recall.

Q. Who have you talked with about your work in this case?

MR. CARDI: I'm just going to object now preliminarily. We're getting close to the area of attorney-client privilege, but I think this question is probably fine as long as we're limiting it to who he spoke with.

MR. CHALOS: I'm not sure I understand that objection.

BY MR. CHALOS:

Q. The question was, who have you talked with about your work in this case, sir?

A. I cannot recall every person I've talked to.

Q. How many people have you talked with?

A. I can't recall that either.

Q. More than ten?

A. I don't think so.

Q. Okay. You spoke with Mr. Cardi about your work in this case?

A. Yes.

MR. CARDI: Objection; foundation.

Q. Have you spoken with any --

MR. CHALOS: I'm sorry, Michael. Were you about to say something?

MR. CARDI: I was just lodging an objection.

MR. CHALOS: Okay.

BY MR. CHALOS:

Q. Have you spoken with anyone other than lawyers about this case?

A. Not that I can recall.

Q. Did anyone help you -- let's leave the lawyers outside. But did anybody help you write your report in this case?

A. You're saying other than lawyers?

Q. Yes, sir.

A. I don't believe so.

Q. And do you have an assistant or a colleague who helped you write the report?

A. I do not have an assistant.

Q. Did any colleague help you write the report other than lawyers?

A. No. That's my report.

Q. Have you ever done work for Mr. Cardi's law firm before this case?

A. Not that I'm aware of.

Q. Your rate of compensation for the work in this case is $400 per hour for the report preparation and $500 per hour for testimony; is that right?

A. I believe that's correct.

Q. How did you come up with those rates?

A. I don't recall exactly how I came up with that.

Q. What do you understand your assignment to be in this litigation?

A. I don't know if I understand your question. I'm sorry.

Q. You were at some point asked to do some work in connection with the Montgomery County litigation, right?

A. I believe so.

Q. What do you understand your work to be in this case? In other words, what were you asked to do?

A. I was asked to provide opinions. My expertise was sought out.

Q. What were you asked to provide opinions about?

MR. CARDI: Object to form, foundation.

A. Opinions regarding my clinical practice, expertise.

Q. What do you understand about the lawsuit that we're here about? What's the lawsuit about?

A. I don't recall the exact specifics.

Q. Do you know anything at all about what the litigation is that you were asked to provide your opinions in?

A. I don't recall specifics of the litigation. My opinions were more regarding clinical practice patient care based on my expertise.

Q. What was your understanding when you were first hired about who you would be working for?

A. I don't recall the specifics surrounding that.

Q. How about today? Do you have any understanding of who you're working for today?

A. Can you ask -- I want to make sure I understand your question. In terms of who am I working for?

Q. Yes, sir. On behalf of what entity are you providing opinions here today?

A. I'm not sure if I can recall the exact entity.

Q. What do you recall about the entity on whose behalf you're providing opinions today? Do you recall anything, or do you know

anything?

A. I want -- can you ask me that question either the same or in a different way. I want to understand it correctly. I'm sorry.

Q. Sure. Yeah. And it's not meant to be a trick question.

You said earlier that you were asked to give opinions regarding your clinical practice and expertise in this litigation, right?

A. Yes.

Q. Who asked you to do that?

A. I don't recall exactly who asked me to do that.

Q. Do you -- did you have any understanding on whose behalf they were asking you to do that? I understand you may not remember their name, but who they were working for? Did you recall that?

A. Who the -- who is who working for?

Q. The person who asked you to give opinions.

A. I can't recall exactly.

Q. Are you planning to testify at

trial in this litigation?

A. I'm prepared to testify if that's what ends up happening.

Q. Did you disclose to West Virginia University that you were providing opinions in litigation about opioids?

A. Yes.

Q. And how did you provide that?

A. There's a standard request submission process.

Q. Did you fill out a form of some kind?

A. Yes, I believe so.

Q. And what did you tell West Virginia University about who hired you to give opinions in opioids litigation?

A. I don't recall exactly what's on the form at this moment.

Q. Did you at some point know who hired you to give opinions in this case and you've forgotten?

A. I'm sorry?

Q. Did you at some point know who hired you to give opinions in this case?

A. At some point. I just cannot recall right now. I don't have any of that in front of me. I know Bowles Rice.

Q. Okay. Who's Bowles Rice?

A. It's the law firm.

Q. Are they the law firm that hired you to work in this case?

A. I believe so.

Q. Do you know who Bowles Rice represents in this litigation?

A. I can't recall exactly who they're representing.

MR. CARDI: Mark, we're getting up in an hour here. Whenever a good time for a break.

MR. CHALOS: Yeah. Okay. That's fine. We can take a break now.

MR. CARDI: All right. 10:10 return?

MR. CHALOS: Yeah, that works.

THE COURT REPORTER: Off the record at 10:01 a.m.

(Recess taken.)

THE COURT REPORTER: We are back

on the record at 10:12.

BY MR. CHALOS:

Q. Doctor, we sent to you over the weekend some documents.

Did you receive that?

A. Yes.

Q. Okay. Do you have that in front of you or near you?

A. I've got a box here. Yep.

- - -

(Marshalek Deposition Exhibit 1 marked.)

- - -

BY MR. CHALOS:

Q. Okay. If you could pull out of that box tab number 2.

A. Okay.

Q. And we'll mark that as Exhibit Number 1 to your deposition. I'll represent to you it's a document that says "Report and Opinions of Patrick J. Marshalek, M.D.," dated December 12, 2022. It's also up on the screen.

Yeah, it's in the notebook, and there should be tabs in there, and we're looking at tab number 2.

A. I apologize. Which tab?
Q. Number 2.
A. Thank you. There.
Q. Do you have that in front of you?
A. Yes, I do.
Q. Okay. Great.
So is this your report in this litigation?
A. Yes.
Q. Does this report contain all of the opinions that you intend to give at trial in this litigation?
A. I want to make sure I'm understanding your question, because I feel like -- if you're saying trial, I may put forth other opinions besides here, if need be.
Q. Okay. So I only get one -- typically one chance to question you about your opinions prior to trial. And to do that, we are relying on your report to contain all of the opinions that you have in connection with the litigation and the bases for those opinions.
As you sit here today, do you have opinions that you intend to give at trial in

this litigation that are not listed in your report?

A. I'm sorry. I'm not sure if I understand that question. I just know I don't know what might be asked of me if this were to advance forward.

Q. Okay. As you sit here today, do you have opinions about this litigation other than what's set forth in your report?

A. I did my best to set out all my -- all my opinions in this report.

Q. Okay. Do you think that there are -- that you have opinions, as you sit here today, that you weren't able to put in your report for some reason?

A. Not that I'm aware of.

Q. Okay. If you would turn -- the report -- the pages aren't numbered in the report. So what I did was, excluding the cover page, I just on my copy handwrote in numbers. So page 1 is background and qualifications, and then I numbered them sequentially from there.

You're welcome to do that to follow along. Otherwise, we're going to put up

on the screen the pages I'm referencing where you can just count along. But that's the convention I use to try to keep orderly here.

So if you would, sir, if you would turn to page 6, which says "Prior Writings."

Do you see that?

A. Yes.

Q. Okay. What's listed here? It's on page 6, 7, and part of 8. What did you intend to list here? Is this all of the writings that you've done, or is this a subset of the writings that you've done?

A. I believe these are my publications.

Q. Are these limited to opioids-related topics, or are these all of the writings you've done on any professional topic?

A. I think the latter is more accurate.

Q. Okay. And then if you turn to page 11, on the top it says "References/Reliance Materials."

A. Yes.

Q. Do you see that?

A. I do.

Q. Are these -- on pages 11 and 12, does this list all of the materials that you considered in connection with forming your opinions in this case?

MR. CARDI: Object to form.

A. I'd want to know how you're defining "considered."

Q. Did you review any other materials other than what are listed in your report either under "Prior Writings" on pages 6, 7, and 8 or under "References/Reliance Materials" on pages 11 and 12 in connection with your work in this case?

A. Yes. It's common practice to spend time in the medical indices, PubMed in particular, and consult a variety of journal practices. I probably do that on a daily basis just in my routine clinical practice.

Q. In connection with preparing your report here, did you review any other documents other than what's listed in your report?

A. Did I review any other documents other than what's listed here? Well, yeah, over

the course of my career and leading up to this, I've reviewed multiple journal articles on these topics and many other topics.

Q. Do you have a list of those journal articles anywhere?

A. No, I do not.

Q. Have you considered those journal articles in forming the opinions that you set forth in your report, Exhibit Number 1?

MR. CARDI: Object to form.

A. I'm not sure which articles you're referring to now.

Q. Okay. So here's the situation, Doctor: The federal rules require that you disclose the facts and data considered by the witness in forming the opinions in the case.

You've given us a list in your report, Exhibit Number 1, of some materials that you considered in forming your opinions here. And now you're telling me there are other materials that you might have considered in forming your opinions; is that correct?

MR. CARDI: Objection; mischaracterizes prior testimony. I

think he's just saying that he's reviewed materials over the course of his career that may be relevant.

Q. Is that what you're saying, Doctor?

A. Yes.

Q. Can you give me a list of the materials that you've considered in the course of your career that may be relevant to the opinions you've set forth in your report in this case?

A. I don't think that would be possible.

Q. As you sit here today, do you recall any materials that you've considered in the course of your career that are relevant to the opinions you've set forth in your report?

A. I'm sorry. I'm having trouble with that question.

Q. Sure.

Do you recall, as you sit here today, any materials that you have considered at any time in forming the opinions that you set forth in Exhibit Number 1, your report in this

case?

A. Again, my clinical practice over years involves interfacing with reading multiple medical journals. My clinical practice surrounds these topics. A lot of that also formed the basis for the opinions in my report. And I'm unable to list you every single journal article I've read over the course of my career. I'm sorry.

Q. Can you list for me the articles that you considered in forming the opinions that you've set forth in Exhibit Number 1, your report in this case?

A. I would -- I would look to the reference and reliance materials then.

Q. Okay. Are there any other materials that you've considered in forming the opinions in your report other than what's listed in your references and reliance materials, in the report itself?

A. Not that I can recall, other than what we discussed.

Q. What did we discuss?

A. My career and clinical practice.

Q. All right. Well, look, we're entitled to know what materials you considered in forming the opinions set forth in your report.

Can you give me a list of those that are not already listed in your report, as we sit here today?

MR. CARDI: Objection; asked and answered.

A. I would look again to the reference and reliance materials.

Q. Can you give me a list of any materials that are not set forth in the reference and reliance materials section of your report that you considered in forming the opinions listed in your report?

MR. CARDI: Objection; asked and answered.

Q. Yes or no?

MR. CARDI: You don't have to answer yes or no.

Mark --

Q. Yes, you do, sir.

MR. CHALOS: Michael, you're in

violation of the rules in a number of respects. Number one, your report is incomplete. Number two, your objections are -- the basis of your objection, and that's it. You're giving speaking objections now.

BY MR. CHALOS:

Q. Dr. Marshalek, I'm asking you a question, yes or no, can you tell me what other materials you considered in forming the opinions set forth in your report other than the materials listed in your Reference/Reliance Materials section?

MR. CARDI: Objection; asked and answered.

Dr. Marshalek, you can answer to the extent you can.

THE WITNESS: I think I tried to previously.

Q. Okay. Do it again, please.

MR. CARDI: Objection; asked and answered.

A. I outlined it in my reference and reliance materials. Other than quantifying what

entailed years of clinical practice surrounding some of these topics that also was relied upon, my clinical experience and expertise.

Q. Are there any other written materials that you considered in forming the opinions set forth in your report other than what's listed in your References/Reliance Materials section?

MR. CARDI: Objection; asked and answered.

A. Again, I thought I tried to answer that as best I could.

Q. Answer it again then, please.

MR. CARDI: Objection; asked and answered.

A. I've outlined the reference and reliance materials, cited them in my report, and also have utilized and relied upon my clinical experience, clinical expertise on this topic.

Q. So there are no other written materials that you considered in forming the opinions in your report other than what's listed in the reference and reliance material section?

A. I feel the Reference/Reliance

Materials substantiate the points I'm making in my report.

Q. There are no other written materials that you considered in forming the opinions in your report other than what's listed in the Reference/Reliance Materials section; is that true or not true?

A. I'm just having trouble with that question, because these are my opinions. My opinions are not simply a regurgitation of these reference and reliance materials. They're based on my training, education, clinical experience, and a host of other activities that deepen my knowledge and understanding surrounding these topics.

These reference/reliance materials I've relied upon to substantiate and cite as standard practice in clinical publications my opinions.

BY MR. CHALOS:

Q. Are there other materials -- leaving aside your experience, other written materials that you relied on to substantiate your opinions?

A. These references and reliance materials are what I utilized to substantiate my opinions.

Q. And no others?

A. Other than what I discussed earlier.

Q. Are there other written materials that you considered in forming the opinions you set forth in your report?

A. Not that I'm aware of.

Q. Okay. Did you read every single word of every single document you listed in the reference and reliance materials?

A. That, I can't recall.

Q. Let's talk about the opinions you've set forth in your report. I count -- let me see, one -- two, three -- four pages of substantive text that make up your report.

Does that sound right in terms of the opinions?

A. I believe so.

Q. If you would turn, please, to page 3 of your report, the second full paragraph from the bottom. It starts with "The 'gateway'

theory."

Do you see that?

A. Yes.

Q. What is the gateway theory?

A. I think it's just that. It's a theory or hypothesis.

Q. Is that the end of your answer?

A. Yes.

Q. The sentence you wrote in your report says, "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to the use of illicit drugs, is unsubstantiated and controversial."

Do you see that?

A. Yes.

Q. Okay. What materials listed in your report support that sentence?

A. Number 14 under my references and reliance materials.

Q. Okay. So the sentence that you put forth in your report says that the gateway theory proposes that the use of prescription opioids directly leads to the use of illicit drugs; is that correct?

A. Yes.

Q. And the support for that sentence you believe is reference 14; is that correct?

A. Reference 14 lists directly after the sentence it was listed, and then clinical experience and opinion regarding this theory, and that it does not match what I've seen in my clinical practice.

Q. Are you aware of any other written material, whether it's an article or textbook or any other writing, that supports your sentence, "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to use of illicit drugs, is unsubstantiated and controversial"?

MR. CARDI: Object to form.

A. Yeah, I think that's the main controversy surrounding it, is that it's a theory. It's a hypothesis. And the causality is not -- has not been proven. That's a common objection. And that's my opinion.

Q. Other than the Miller article that you've listed as reference 14, are you aware of any other medical article or any other writing

that supports your sentence on page 3 of your report about the gateway theory?

A. Can you repeat your question, please.

Q. Sure.

Are you aware of any other writing, medical article, textbook, anything else in writing, leaving aside your clinical experience, that supports your sentence about the gateway theory on page 3 of your report?

A. I can't right here right now recall specific other writings. It's mainly my clinical experience as well.

- - -

(Marshalek Deposition Exhibit 2 marked.)

- - -

BY MR. CHALOS:

Q. Let's -- if you would turn, please, to Tab 5 of your notebook, which is the reference I believe number 14 in your report, Michael L. Miller, and Yasmin, Y-a-s-m-i-n, L. Hurd, H-u-r-d, commentary called "Testing the Gateway Hypothesis." And that's published in Neuropsychopharmacology 2017, Volume 42, pages

985 through 986.

Do you see that document, sir? It's Tab 5 of your notebook.

A. Yes.

Q. Is this the document that you cited at footnote 14 of your report on page 3?

A. I believe so.

Q. Would you read the first sentence of that document, please.

A. "The gateway drug hypothesis refers to the pattern of substance use during adolescence whereby legal substances, such as nicotine and alcohol, precede the progressive use of illicit substances like cocaine and heroin."

Q. That is a different gateway theory than the gateway theory that proposes the use of prescription opioids directly leads to use of illicit drugs, right?

MR. CARDI: Object to form.

A. Yeah, I'm not sure what you mean by that.

Q. Okay. The gateway hypothesis referred to in your report, as you define it,

proposes that the use of prescription opioids directly leads to the use of illicit drugs, correct?

A. I'm not sure if I understand that.

Q. Okay. The words you use on page 3 of Exhibit 1, second full paragraph from the bottom, are these: "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to use of illicit drugs, is unsubstantiated and controversial."

Correct?

A. That's what I read. Yes.

Q. Okay. And the citation you used to support that is the Miller article, correct?

A. The Miller article is more to substantiate I believe the last sentence that the 14 is attached to.

Q. Okay. What then supports your sentence, "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to use of illicit drugs, is unsubstantiated and controversial"?

MR. CARDI: Objection; asked and answered.

A. Again, I think I would look to the last paragraph in that article.

Q. In what article?

A. The article that we were just looking at.

Q. The article about, "The gateway hypothesis that refers to the pattern of substance use during adolescence whereby legal substances, such as nicotine and alcohol, precede the progressive use of illicit substances like cocaine and heroin"?

A. No. It's the sentence that says, "Despite the growing number of published papers relevant to the gateway drug hypothesis, many complex factors still have not been thoroughly addressed to determine causality in animal models, excluding -- even excluding human-specific confounds that impact interpretations such as social, psychological, and legal considerations."

Q. And you think that the Miller article refers to the use of prescription opioids directly leading to the use of illicit drugs?

A. I'm not sure if I understand that question.

Q. You think the Miller article is about opioids?

A. This article is about this theory. Opioids have been used to kind of put into this theory. You know, the theory had normally been, oh, you started smoking cigarettes and lead to alcohol, and you kind of move stepping stone -- in a stepping stone pattern or kind of on to harder and more and more drugs as your illness evolves. And that just does not -- does not click with what I've seen clinically.

Q. Do you, Doctor, think that the Miller article, gateway drug hypothesis, is about opioids?

MR. CARDI: Objection; asked and answered.

A. I'm not sure how to answer that question. I think this theory has been used in a variety of ways, and I don't like how it's been used because I don't think causality.

It stemmed from epidemiologic studies initially, and it's not really relevant

I'm finding it in clinical practice based on the key part, key criticism of it, and the causality has yet to be established.

Q. Have you read any articles at all other than the Miller article about the gateway theory as it relates to opioids?

A. I can't recall the exact articles.

Q. Have you read any of them?

A. I can't recall what I've read over the course of my career exactly.

Q. Can you point to any article that says the gateway theory from prescription opioids to illicit opioids is unsubstantiated and controversial other than, in your opinion, the Miller article?

A. I cited a common criticism of this theory is the causality is yet to be established. That's why I feel it's unfair to point the finger at any one given substance and say it's causing an illness. It's complex and still poorly understood as addiction.

Q. Who else says that other than you?

A. I can't recall exactly who all says that.

Q. Can you tell me a single person other than you who says that, sir, with respect to opioids?

A. I can't recall specific people right at this moment.

Q. Have you ever --

MR. CHALOS: I'm sorry. Was somebody speaking?

MR. CARDI: Yeah. That was me, Mark. I thought we were at a breaking point. I just wanted to point out that I think you referred to Tab 2 as Exhibit 1, and I don't recall it being marked. I just wanted to point that out.

MR. CHALOS: The report?

MR. CARDI: Yes. Maybe it was. I apologize. I just -- I didn't recall it, so I wanted to point that out in case it wasn't.

MR. CHALOS: Yeah, so tab 2, Dr. Marshalek's report, was marked as Exhibit 1, I believe.

And marked as Exhibit Number 2 to

this deposition is tab number 5, the Miller and Hurd article, "Testing the Gateway Hypothesis." First sentence, "The gateway hypothesis refers to the pattern of substance use during adolescence whereby legal substances, such as nicotine and alcohol, precede the progressive use of illicit substances like cocaine and heroin."

That's Exhibit Number 2 to this deposition.

MR. CARDI: Okay.

BY MR. CHALOS:

Q. And you, Doctor, have actually given a presentation about the process of patients moving from prescription opioids to heroin, haven't you?

MR. CARDI: Objection.

A. Ask me again. I'm sorry.

Q. Sure.

You have given a presentation about patients moving from prescription opioids to heroin, haven't you?

MR. CARDI: Objection.

A. Which presentation are you speaking of?

Q. All right. Let me ask you a different way.

Have you ever given a presentation that includes a discussion of patients moving from prescription opioids to heroin?

A. It's likely I would have discussed that based on discussing the nature and extent of a substance use disorder. A patient with opioid use disorder is going to utilize opioids in order to avoid the withdrawal from that after they've achieved tolerance and dependence. And at that point in time, the illness itself does not discriminate which opioid to seek out. It just seeks out opioids.

Q. In your clinical experience, patients who develop opioid -- patients can develop opioid use disorder while taking prescription opioids, correct?

A. That's my point. You can develop use disorders to a host of substances, whether it's prescription, illicit, however you want to define them. And I think not only -- substances

are not the only thing people can have use disorders. It doesn't have to be a substance.

Q. In your experience, have you had patients develop opioid use disorder while taking prescription medication medically?

A. I'm having trouble with that question, understanding what exactly you mean by taking -- that last part of it. I'm sorry.

Q. Sure.

Have you ever heard the term taking opioids -- prescription opioids medically versus non-medically?

A. I may have.

Q. Okay. What do you understand about the difference between medically and non-medically?

A. I think it can mean different things. It depends on kind of who's interpreting it and how.

If I write a prescription for a patient, I'm giving them very specific detailed instructions on how to take the medication; how much to take, how often to take it, what route of administration, and kind of also the duration

of therapy. So that, in my opinion, would more like likely mirror what medical use is.

Q. What's non-medical use?

A. Kind of, again, after the kind of informed assessment, informed consent process and so on.

Q. What is non-medical use?

A. I think anything that's not that, in some ways.

Q. In your clinical practice, have you seen patients develop opioid use disorder that were taking opioids medically, prescription opioids?

A. I want to make sure I'm understanding your question correctly.

Q. Okay.

A. So if you could please repeat it. I apologize.

Q. Sure.

In your clinical practice, have you ever treated a patient for opioid use disorder who started taking opioids medically and progressed to develop opioid use disorder?

A. I think so.

Q. A patient taking opioids medically can develop opioid use disorder, right?

MR. CARDI: Objection; asked and answered.

A. What did I -- I'll just give the same answer I gave before.

Q. All right. Well, let's do it again.

When he says "asked and answered," you can ignore that. He's not trying to coach you. He's just making a record here. So you can ignore that and just answer the question.

So my question is to you: A patient taking opioids medically can develop opioid use disorder, right?

A. I've seen that in my clinical practice. You're saying "medically." That gets a little tricky, I think. I think I'd have to -- I could start to describe clinical situations and give context. I wouldn't want to kind of have that a broad-based statement.

Q. Well, you've certainly seen patients who took prescription opioids as prescribed -- I'm not talking about you

prescribing them the opioids, but a doctor prescribing them opioids, they followed their doctor's instructions, and developed opioid use disorder.

You've seen that, right?

MR. CARDI: Asked and answered.

A. I've taken care of patients that have been cared for, unfortunately, by pill mills. So they started out and they weren't screened adequately. They were drinking. I know they had an alcohol use disorder that went ignored. They were prescribed high dose regimens that were above and beyond what they probably should have been prescribed --

(Court reporter clarification.)

THE WITNESS: I'm sorry.

A. These are patients of pill mills prescribed high dose opioid regimens, potentially not legitimately, and they're taking them, quote, as prescribed, end quote, and end up having -- developed an opioid use disorder based on the fact that they weren't screened. They were given more of something than what they needed and may have been misusing it from the

get-go and using other things with it.

So, I mean, I think, to me, it's incredibly complex what may be going on behind the scene. I've taken care of patients that were taking their prescribed opioids, but then also supplementing with opioids from elsewhere. So on paper, it looked like they were taking it as prescribed.

So I think they're just -- all the different paths and clinical scenarios I could go on and on about, but ...

Q. In order to develop opioid use disorder, a patient must have exposure to opioids, right?

A. You're saying you have to be exposed to opioids. Not everyone that is exposed to opioids develops an opioid use disorder.

Q. But everyone who develops an opioid use disorder has been exposed to opioids, correct?

A. In some way. And I think that's the core of these use disorders, in my opinion. It's development of an unhealthy relationship

with that substance. That's where the substance, I think, becomes less important. It's more the relationship with it and then the dysfunction that begins to surround that unhealthy relationship. And that's why it can evolve to include things other than substances.

So, for example, I've taken care of patients with opioid use disorder that then have developed metabolic syndrome because they've developed an unhealthy relationship with food.

Q. Let's look at tab 7 in your notebook. We'll mark that as Exhibit Number 3.

- - -

(Marshalek Deposition Exhibit 3 marked.)

- - -

BY MR. CHALOS:

Q. What is this document, Doctor? You can take as much time as you need to review it.

A. This is a trip down memory lane. I think this is I think a project that we worked on. It was connected to I think the work I was doing at the time at WVU regarding trying to

improve access to treatment for opioid use disorder utilizing telehealth. We wanted to let people know kind of why we were doing that and how.

Q. Who did you give this presentation to?

A. I can't recall exactly. I've given several or multiple presentations on this topic.

Q. Do you recall when you gave this presentation?

A. No. Sorry.

Q. Turn, if you would, to -- well, I don't know how you can count it, but it's about a little more than halfway through. The slide says "TELECOAT," T-E-L-E-C-O-A-T, and it has your name on it. It's probably 60 percent of the way through the deck.

Do you see that?

A. Hold on one second.

Q. Yeah. No rush. You can take as much time to review the whole document if you'd like.

A. You're saying TELECOAT?

Q. That's what it says.
A. Okay. You're saying this is multiple people.
Q. It looks like a slide deck that includes slides for multiple people. You're the third, and so you're probably more than 60 percent.
A. I'm there now.
Q. Okay. It looks like that (indicating). I don't know if you can see it.
So it says, "TELECOAT." What does TELECOAT mean?
A. COAT is an acronym that refers to comprehensive opioid addiction treatment. It's a term utilized to describe our group's approach to treating opioid use disorder and utilizing medications for opioid use disorder.
TELE just was placed in front of it to basically demonstrate that we utilize this model. We deployed this model through TELE to some of the harder hit areas in West Virginia.
Q. Was this before the pandemic?
A. Yes.
Q. If you flip to the next page after

"TELECOAT," it says "Opioid Epidemic." And then the first bullet says "Rx -- arrow -- heroin."

Do you see that?

A. Yes.

Q. All right. What did you discuss, if you recall, about Rx with the arrow to heroin?

A. Likely discussed the fact that this was likely after I think the CDC started flying the flag about prescription opioids, and people were noticing the deaths, and the number of overall prescriptions was decreasing. That's what we were seeing clinically.

So despite the fact that the opioid prescriptions were decreasing, it didn't really change the overall number of patients that we were seeing struggling with opioid use disorder.

And as I mentioned earlier, if you have an opioid use disorder, you don't -- regardless of how you arrived at it, you don't really discriminate with respect to what opioid you'll end up utilizing.

Q. All right. Let's -- and do you

recall -- when they started reducing the number of opioids prescriptions, do you recall what was happening nationwide to the percentage of patients using illicit opioids?

A. I'm sorry. Can you repeat that.

Q. Do you want me to try that again?

A. Yes, please.

Q. Sure.

At the time when the number of prescriptions for opioids was decreasing, do you recall what was happening with the number of patients using illicit opioids, such as heroin and fentanyl? Was it increasing or decreasing?

A. I think -- I still was seeing a decent amount of patients suffering from opioid use disorder. They were using a variety of opioids.

Q. Including illicit opioids?

A. Probably.

Q. Let's turn to tab 8. We'll mark this as Exhibit Number 4.

- - -

(Marshalek Deposition Exhibit 4 marked.)

- - -

BY MR. CHALOS:

Q. This is another PowerPoint presentation with your name listed first on it. It says, "The Road Less Traveled: Using Buprenorphine-Naloxone to Treat High Risk Chronic Pain Patients."

Do you see that?

A. Yes.

Q. Okay. What is this document?

A. This was -- I think we were asked -- we were invited to present this. I can't recall the -- yeah, the PCSS asked us to do this training.

Q. What is PCSS?

A. It's Providers' Clinical Support System for opioid therapies.

Q. Is that a private organization?

A. I don't know.

Q. All right. If you turn to the second page -- page 2 of Exhibit Number 4. The slide on the bottom, "How did we get started?"

Do you see that?

A. Yes.

Q. The last bullet point there says,

"Buying pain pills off street, turning to illicit drugs, experiencing withdrawal."

Do you see that?

A. Yes.

Q. All right. Do you recall what your point there was?

A. I think our point was, because we were talking about pain management, was -- I think this is kind of connected to that pendulum swing that is often discussed where the push was to focus on pain and then treat it at all costs. And then as we kind of started to realize some of the costs associated, it got pushed over the other way.

And I think caught in the middle were a lot of patients that had been prescribed opioids without a lot of screening, without a lot of oversight. And it just -- it varied widely I guess is the best way I could say it.

So these were the patients our team was seeing, these patients that were hospitalized, and they were in opioid withdrawal, and we weren't sure if they were in opioid withdrawal because they were seeing a

pill mill unknowingly and they presented to the emergency department at 3:00 in the morning after they started to run out of medication and didn't know where else to go get it.

You know, providers were prescribing less, and they looked, at first glance, maybe like they did have a use disorder. They really didn't. They were just experiencing withdrawal.

So we were trying to find a way to target some of this population or come up with a kind of clinical approach to treating them because very often you weren't really able to figure out everything you needed to in the context of one quick visit. You needed to be able to kind of assess, diagnose, and treat in the context of continuity. And then some of those risk factors that we would identify could also be, I think, modified and/or treated.

Namely, if we brought on a patient that we felt had risk factors and those were simply a fact that they weren't getting good care and they had really bad depression and that needed treated, then we modified those,

decreased the risks, improve their outcomes.

Whereas, you know, some of them were to actually -- needed -- in order to have their pain adequately treated, they needed to be moved more in the direction of formal addiction treatment, kind of like a router. That was the programming.

We utilize buprenorphine, which is an opioid analgesic, in those cases to take advantage of some of the benefits that also make it a good medication for those with opioid use disorder.

Q. Turn, if you would, please, to tab 16 of your notebook. We'll mark this as the next numbered exhibit, which I think is Exhibit 5.

- - -

(Marshalek Deposition Exhibit 5 marked.)

- - -

MR. CHALOS: Is that correct, Madam Court Reporter?

THE COURT REPORTER: Yes.

TRIAL TECH: Yes, sir.

BY MR. CHALOS:

Q. We're going to mark as Exhibit 5 an article by McCabe, et al. entitled "Pills To Powder: A 17-Year Transition From Prescription Opioids to Heroin Among U.S. Adolescents Followed Into Adulthood."

This was published by the Journal of -- published in the Journal of Addiction Medicine, Volume 15, Number 3, May/June 2021.

Have you, Doctor, heard of the American Society of Addiction Medicine?

A. Yes.

Q. Are you a member of it?

A. Not that I'm aware of.

Q. Okay. Have you ever heard of the Journal of Addiction Medicine?

A. Yes.

Q. And that's a peer-reviewed journal?

A. I believe so.

Q. I'm sorry. Did you say you do not believe so or you do believe so?

A. I'm sorry. I didn't speak up there.

I believe so.

Q. Okay. Do you know any of the doctors listed as authors of this publication?

A. Not that I'm aware of.

Q. Do you subscribe to the Journal of Addiction Medicine?

A. Not that I'm aware of.

Q. Do you subscribe to any medical journals?

A. Not that I'm aware of.

Q. Do you read on a regular basis any medical journals?

A. Yes.

Q. Which journals do you read on a regular basis?

A. I can't recall. I read a wide variety. Based on the fact that I work at an academic institution, I utilize the libraries within our organization, and then the -- they have subscriptions to those on our behalf, so I can access them electronically.

Q. Okay. Have you ever reviewed any articles published in the Journal of Addiction Medicine?

A. I may have. It's likely that I have.

Q. Okay. Have you ever reviewed any articles published in the New England Journal of Medicine?

A. It's likely that I have.

Q. Okay. Let's look at Exhibit Number 5, the "Pills to Powder" article written by Dr. McCabe and others.

Have you ever seen this article before today?

A. I don't believe so.

Q. Okay. Look at the section entitled "Conclusions." It's on the first page of Exhibit 5.

Do you see that?

A. Yes.

Q. Okay. Can you please read that first sentence under "Conclusions"?

A. "There is increased risk for heroin use among adolescents who initiated non-medical misuse or adolescents prescribed opioids in more recent cohorts."

Q. Okay. Do you have any reason to

dispute that as a conclusion of Dr. McCabe and his colleagues?

A. I would need to apply -- I would need to look through this article and dig deeper into it as I would any article before I kind of just take the conclusion at face value.

Q. Okay. Well, let's look at Table 2 of this article, and take as much time as you need to review it. We can take a break if you want to review the entire article. It's only three pages, four pages.

Do you want to do that, or do you want to go through it with me?

A. I don't mind either way. I can look at it with you.

Q. All right.

A. If I need more time, I'll let you know.

Q. Okay. Let's look at Table 2 here. It's titled "Prevalence and Adjusted Odds of Heroin Use Over 17 Years as a Function of Medical Use and Nonmedical Misuse History of Prescription Opioids During Adolescence."

Do you see that?

A. Say that again, please.
Q. Yeah. I'm just reading the title of Table 2.
A. Yes.
Q. Do you see the title there?
A. Yes, I see it.
Q. Okay. They -- this uses a term "AOR" that they define as adjusted odds ratio.
Do you see that?
A. Yes.
Q. What is an odds ratio?
A. I don't recall the exact definition.
Q. Is that an epidemiological term?
A. I don't recall exactly who kind of owns that term. It's utilized in research.
Q. Okay. Do you know what it means?
A. Like I said, I don't know the exact definition of it right here right now as I sit.
Q. Do you know the definition of the term "odds ratio" in an epidemiological context?
A. I'm familiar with that but unable to recite or recall an exact definition as we

sit here.

Q. Okay. And then they also use this term "CI."

Do you see that?

It's in the heading where it says "Baseline Opioid Exposure (Modal Age 18)."

Do you know what a mode is?

A. I mean, these -- I'm familiar with statistics, as many articles report back topics, and these are statistical terms.

Q. Okay. What does "mode" mean in the statistical context?

A. I can't recall exact definition.

Q. Okay. And then do you see it says AOR -- the first column, "AOR (95 percent CI)"?

A. Yes.

Q. Do you know what a "CI" is?

A. They likely refer to what that is somewhere here. Typically it means confidence interval, but I'd want to see -- I'd want to make sure that they -- usually somewhere -- the first time they state that in an article, they'll usually abbreviate it thereafter. So I just want to make sure that that's --

Q. Okay. Let's assume it means confidence interval. What is a confidence interval?

A. Again, it's the physical term. I can't -- I'm unable to recall, I apologize, the exact definition as we sit here.

Q. Okay. And then it says in that first column, AOR, adjusted odds ratio, and then it says 95 percent CI. And then there's a little symbol. And if you look at the reference to the symbol there, it refers you down into the -- underneath the table.

Do you see that?

A. I see some p-values.

Q. Yeah. Right. Let's look -- so there's a couple different instances of p-values.

Do you know what p-values are, what that term means?

A. These are a variety of statistical terms that as we sit here now I'm unable to recall the exact or precise definition. So I apologize.

Q. All right. So if we look at the

right column here, it says, "Recent baseline cohorts (1997 to 2000) heroin use ages 19 to 35."

Do you see that? It's the right-hand column of Table 2 of Exhibit Number 5.

A. You said which one again? I apologize.

Q. Yeah, the column on the right, "Recent Baseline Cohorts."

A. Yes. Yes.

Q. Okay. So if you look at the "medical use only" row, it shows an adjusted odds ratio of 2.68.

Do you see that?

A. Yes.

Q. Do you know -- do you have any idea what that means?

A. Again, this is getting -- I would -- this is getting into statistical kind of referencing.

Q. Okay. Do you know whether this article, the McCabe article, Pills to Powder, Exhibit Number 5 -- do you know whether this

substantiates the gateway theory of prescription opioids to heroin use?

A. I don't believe it does. I believe it just only demonstrates, you know, correlation, not necessarily causation.

Q. Why do you say that?

A. Because that's a limitation of a study like this based on how it's designed.

Q. How is this study designed?

A. The methods outline that. The discussions in the article would have to kind of touch on that as well. There are many studies like this.

Q. Like what?

A. That demonstrate a wide variety of -- not just with opioids. Many studies, whether they make it to news media or stay in journals, they demonstrate a wide variety of correlations, but that does not equal causation. That's a pre-foundational teaching topic for those that are kind of initially approaching literature such as this.

Q. Does this analysis that's reflected in the McCabe paper, Pills to Powder,

Exhibit Number 5, does this analysis establish that there was an increased risk for any subsequent heroin use among adolescents who had already initiated non-medical prescription opioid misuse and adolescents prescribed opioids in more recent cohorts?

MR. CARDI: Object to form.

A. Again, I just want to say that correlation doesn't equal causation.

Q. Okay. Do you understand the concept of increased risk?

A. I'd want you to define increased risk. I mean, I think it -- risk can mean a lot of different things in a lot of different contexts. I know it doesn't mean cause.

Q. Is it your belief that there is no plausible, biological explanation for exposure to prescription opioids causing heroin use later?

A. I'm sorry. I had trouble following that question.

Q. Okay. Well, let me back up then a little bit, and let's see if we can put it into context.

Are you familiar with the Bradford Hill criteria?

A. I don't recall the exact criteria, as we sit here.

Q. Okay. Have you ever heard of the Bradford Hill criteria?

A. I believe I've heard of it before.

Q. Okay. And what is it in general terms?

A. I don't -- I'm unable to recall, as we sit here.

Q. Okay. What do you know about the Bradford Hill criteria?

A. I've heard the term used before.

Q. But you don't know what it means?

A. I can't recall exactly, as we sit here.

Q. Do you believe that for epidemiologists, to establish a causal relationship between two variables, that they must establish a plausible mechanism between cause and effect?

A. Can you repeat that, please.

Q. Sure.

Do you believe, in your opinion, that for an epidemiologist to establish a causal relationship between two variables, that the epidemiologist must establish a plausible mechanism between cause and effect?

A. That question comes to me -- it feels vague because I think as far as the complex illness of addiction, it gets way more challenging, so I don't -- I'm not sure if you're kind of -- that's open enough to say that there could be scenarios.

I think with addiction, the challenge is kind of establishing causality, the bar is much, much higher because of the complex nature of this illness and the variety of factors that can contribute.

Q. Have you ever reviewed any of the data from the National Survey on Drug Use and Health, sometimes called NSDUH?

A. I don't recall exactly.

Q. As part of your work in this case, did you review any of the NSDUH data?

A. I don't recall.

Q. As part of your work in this case,

have you reviewed any articles or any data that address the question of whether exposure to prescription opioids is a risk factor for using illicit opioids?

A. Sorry. I'm having trouble with that question.

Q. Sure.

Have you -- as part of your work in this case, have you reviewed any articles or any data about the question of whether exposure to prescription opioids is a risk factor for later using illicit opioids?

A. I don't believe so.

Q. You know that there are a lot of articles out there that establish through data that exposure to prescription opioids is a risk factor for later using heroin, right?

MR. CARDI: Object to form.

A. Again, I think I discussed this when I gave my opinion on the gateway theory, and then also with respect to studies that establish correlations but not necessarily causations. And the challenges of doing so with respect to an illness as complicated as

addiction.

Q. Okay. Have you read any articles that establish a correlation between use of prescription opioids and later use of heroin and other illicit opioids?

A. I don't recall the specifics, other than the fact that we discussed anyone with a use disorder, opioid use disorder, there's really not a discrimination regarding what -- you know, what opioid they end up having an unhealthy relationship with, unless it's their own preference.

MR. CARDI: Mark, we're at an hour here. Whenever it's a good time for a break.

MR. CHALOS: All right. We're not quite there yet, but we'll take a break relatively soon.

- - -

(Marshalek Deposition Exhibit 6 marked.)

- - -

BY MR. CHALOS:

Q. Let me -- please turn to page -- sorry -- tab 15. We'll mark as Exhibit Number 6

this article. It's by Cicero, et al. The title is "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years." Published in the JAMA Psychiatry. It's a Journal of the American Medical Association, Psychiatry, 2014, Volume 71 (7), pages 821 to 826, published May 28, 2014.

Are you, Doctor, a member of the American Medical Association?

Sorry. I didn't catch that. Was that yes?

A. No. Sorry.

Q. Okay.

A. You asked me -- I want to make sure I understand. You asked me if I am a member?

Q. Right. Are you a member of the American Medical Association presently?

A. No.

Q. Have you ever been a member of the American Medical Association?

A. I don't recall.

Q. Have you ever read the Journal of the American Medical Association, Psychiatry?

A. I may have.

Q. Okay. Take as much time as you need to review this article.

My question to you first is going to be: Have you ever seen this article that we've marked as Exhibit Number 6 before today?

A. I can't recall.

Q. Have you ever participated in any clinical studies as a researcher?

A. I believe so.

Q. Okay. Related to opioids in any way?

A. I believe so.

Q. Okay. What studies have you participated in?

A. I can't recall all the exact studies. Being at an academic center, we often collaborate if a discipline is joined together.

Q. Do you recall any studies that you've participated in as a researcher related to opioids?

A. Can you define what "related to opioids" means?

Q. Have you -- do you recall any

studies that had anything at all to do with opioids that you've participated in as a researcher?

A. Yeah. Many of those have been published.

Q. Okay. So they're listed in your report; is that right?

A. I believe so.

Q. Have you participated as a researcher in any studies that are not listed in your report?

A. Those would be yet to be published. They're still ongoing research activities.

Q. Do any of those relate to opioids or involve opioids in any way?

A. I don't recall the exact -- I'd have to look and see. I don't know exactly everything. Any -- yeah, I mean -- I don't think so, no, but I can't be 100 percent sure. I'm just not able to recall.

Q. All right. Well, let's look at page 823. It's the one, two -- third page of Exhibit 6, Figure 1.

Do you see that?

A. Figure 1?

Q. Yes, sir. It's on the right side.

A. Yes. I see it.

Q. Okay. And the title of this is, "Percentage of Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of Abuse."

Do you see that?

A. Yes.

Q. And if you look at the line graph, do you see the line with the circle says "Prescription Opioid," and the line with the square says "Heroin"?

A. Yes.

Q. And if you look from 2000s through the 2010s, it shows that for those two decades, between 60 and 75 percent of the sample reported prescription opioids as their first opioid of abuse.

Do you see that?

A. Where exactly?

Q. If you look at the 2000s on the X axis.

A. Yes.

Q. You go up from there to the line with the circle on it, right there, and it's about, I don't know, 74, 75 percent of the sample.

A. Yes.

Q. Do you see that?

A. Yes, I see it.

Q. And then if you look at the 2010s, it's somewhere about 65, 64, 65 percent.

Do you see that?

A. Yes.

Q. And the conclusion that the authors in the Journal of American Medical Association, Psychiatry, Dr. Cicero, et al., reached here is that 75 percent of those who began their opioid abuse in the 2000s reported that their first regular opioid was a prescription drug.

Do you agree that that's what's reflected in this chart?

A. You referred where after we looked at the chart again?

Q. Well, if you look at the chart,

you can -- what I just read is from right underneath the chart under "Opioid Abuse Initiation," the paragraph that starts with Figure 1.

A. I think, again, correlation doesn't equal causation. I think this -- I see this, and it reminds me of a statement I made in my report, which is addiction -- if there's been an addiction epidemic, it doesn't discriminate whether it's prescription opioids or heroin. So it's like heroin was the problem, and now it's prescription opioids, then it's heroin.

So I think that this illness really doesn't discriminate, and it doesn't care if it's opioids. It looks for anything to burn through, and it's fueled by more than just I think a substance in and of itself. The substance is not what causes this illness. That's my opinion.

Q. Do you believe that the rate of opioid use disorder in the United States has been consistent for the last, let's say, 50 years?

A. I'm not -- as we sit here, I'm not

able to answer that question.

Q. Have you seen any data that establishes the rate of opioid use disorder increased substantially as the number of opioid prescriptions increased?

A. Can you ask that again?

Q. Sure.

Have you ever seen any data that establishes that the rate of opioid use disorder in the United States increased substantially as the number of opioid prescriptions increased?

A. I can't recall, as we sit here.

Q. Do you know one way or the other whether that's true?

A. Whether there are more patients with opioid use disorder now?

Q. No. That the rate of opioid use disorder increased substantially as the number of opioid prescriptions increased?

A. I can't recall, as we sit here.

MR. CHALOS: All right. Let's take a break.

THE COURT REPORTER: We are off the record at 11:26 a.m.

(Recess taken.)

THE COURT REPORTER: We are back on the record at 11:36 a.m.

BY MR. CHALOS:

Q. Doctor, in connection with your work in this case, did you do any literature searches?

A. Yes. It's common. I'm in the literature all the time.

Q. Okay. Did you do that specifically in connection with your work here for your report?

A. That's hard, because I'm just in it so often for routine clinical practice and then over the course of my career, and, yes, for the report.

Q. What searches did you do specifically in connection with preparing your report in this case?

A. That, I'd have trouble recalling.

Q. How did you find the articles that are listed in your report?

A. They're indexed in PubMed, the database.

Q. Did you find all of the articles that are listed in your report?
A. Did I find?
Q. Yes, sir.
A. What do you mean by that?
Q. In other words, did anybody direct you to these articles, or did you just do literature searches and found the articles that are listed in your report?
A. More the latter.
Q. Okay. So you found the articles that are listed in your report?
A. Yes.
Q. How did you do that?
A. Utilizing the database that's PubMed.
Q. In the course of doing your literature searches, did you find any articles that addressed the correlation between exposure to prescription opioids and the later use of illicit opioids?
A. I have difficulty recalling that.
Q. Would you keep any record of your literature searches?

A. I don't believe so. That's not my standard practice.

Q. Okay. Did you find in the course of your literature searches either the Cicero article or the McCabe article that we discussed so far today?

A. I don't recall.

Q. How did you decide which articles to include in your report?

A. Again, I practiced clinically for a number of years, and that clinical experience is invaluable. That also requires regular interfacing with these indices and these journal articles.

So I've read countless articles, too many to count and recall that if all either kind of informed my practice or maybe not, depending on my interpretation of the evidence put forth by those articles.

It's my job as a clinician to kind of critically analyze the evidence base that grows. These evidence bases grow, and then it go to inform standards of care. That's where I live, seeing patients, treating patients.

That's my primary job.

Q. How did you decide what articles to include in your report?

A. I don't recall exactly my decision-making process, other than what I just discussed. Much of my experience, much of my familiarity with what's written -- or not necessarily the specifics, but what would be referred to as evidence bases.

Q. Surely in your -- oh, I'm sorry. Go ahead.

A. No. Go ahead.

Q. Surely in your search of the literature, you found articles that did not support or maybe even contradicted some of the statements in your report, correct?

A. That's possible. I think, again, that's my job as a clinician, to weigh these evidence bases and determine how I'm going to let the evidence that emerges every time something is published, if that's sufficient enough evidence to shift my practice.

Q. But you chose not to include in your report any articles that contradicted any

of your statements, right?

A. My report contains my opinions. My references substantiate those.

Q. Did you include in your report any references that contradict any of your opinions?

A. Not that I recall.

Q. And you understand that part of the process of making opinions based on medical literature and research is the back-and-forth among scholars where some might disagree, right?

A. My career has been in an academic setting, so I'm familiar with that.

Q. And it's possible that some of your opinions are wrong?

A. What do you mean by that? I'm sorry.

Q. Okay. It's possible that some of the statements that you've made in your report are, in fact, wrong? They're just not correct, right?

A. They're just my opinions.

Q. Right. So they might be right. They might be wrong.

MR. CARDI: Object to form.

A. We could just say that they're my opinions.

Q. Is it possible some of them are wrong, Doctor?

A. These are my opinions as I hold them now and outlined in this report. That's all they are.

Q. And there's certainly data out there that contradict your opinions, right?

I'm sorry. What was your answer?

A. I'm sorry. I want you to ask that again.

Q. Sure.

There are certainly data out there that contradict your opinions, correct?

MR. CARDI: Object to form.

A. There may be.

Q. Have you ever seen any of the evidence that established that restricting prescription opioid supply among those who are dependent on opioids has led to an increase in heroin use?

A. I'm sorry. I missed the first part of that question.

Q. Sure.

Have you seen any of the evidence that establishes that restricting the prescription opioid supply among those who are dependent on opioids has led to an increase in heroin use?

A. I can't recall right now, as I sit here.

Q. Is that consistent with what you've seen in your clinical practice?

A. Is what consistent? I'm sorry.

Q. That the restriction of prescription opioid supply among those who are dependent on opioids has led to an increase in heroin use?

A. I'm sorry. I'm having trouble with that question.

Q. Okay. What's your trouble with it?

A. I want to make sure I'm understanding it correctly. I think I want to hear the first part again.

Q. Okay. In your clinical practice, have you seen that the restriction of the

prescription opioid supply for those who are dependent on opioids has led to an increase in their heroin use?

A. I think currently it's more fentanyl, I would say.

Q. Okay. So let me ask it more broadly.

Have you seen in your clinical practice that the restriction of the prescription opioid supply among those who are dependent on opioids has led to an increase in illicit opioid use?

A. My clinical practice, the patients I care for with opioid use disorder, especially those with severe disorder, really don't discriminate. They use whatever opioid that's the most easily assessable and/or cheapest. They don't discriminate.

Just like the illness of addiction itself, I stated before I don't feel discriminates regarding what substance. It can shift from one to the other, and it does not have to be a substance.

Q. Do you agree that a small but

significant proportion of individuals who used prescription opioids have progressed to heroin use?

A. There are a few words at the beginning part of that question I'd like to hear again.

Q. Sure.

Tell me if you agree with this statement: A small but significant proportion of individuals who use prescription opioids progressed to heroin use?

A. I don't know if I agree with how that's phrased.

Q. Okay. What's your disagreement?

A. The juxtaposition of small but significant.

Q. Okay. How about this: Some individuals who use prescription opioids progress to heroin use?

A. I've seen that clinically. That fails to really take into account what was going on before the prescription opioids, which is often overlooked, in my opinion, clinically.

Q. If you would, sir, can you please

turn to Exhibit Number 1, which is your report in this case, page 9, which is your prior testimony.

A. Yes.

Q. Okay. You've listed four matters in which you've provided testimony at trial or a deposition during the prior four years.

Do you see that?

A. Yes, I do.

Q. Okay. Let's talk about these in order. The first case is the United States versus Brizuela. I don't know if I'm pronouncing that correctly.

A. I believe so.

Q. Okay. And then the second case is the United States versus Brizuela and Naum, N-a-u-m.

Are those the same case, or are those different cases?

A. Those are different.

Q. All right. Let's talk about the first one then, United States versus Brizuela.

Did you give testimony at trial or just in a deposition?

A. Brizuela, it was testimony in court, the trial.

Q. Is that a criminal case?

A. Yes.

Q. And what was the nature of your testimony?

A. That he was running a pill mill.

Q. Okay. Brizuela was a doctor?

A. Yes.

Q. And you testified on behalf of the government?

A. Yes.

Q. And the government was prosecuting Dr. Brizuela criminally?

A. I believe so.

Q. Okay. And how did that case turn out?

A. I can't recall the specifics, but I think it resulted in a -- I don't want to misuse the legal term, so -- I think there was a conviction, though, if that's the right way to say it or ...

Q. Did Dr. Brizuela go to prison?

A. I'm not aware of any of those

outcomes downstream of ...

Q. Approximately when was that that you testified in the trial in the United States versus Brizuela?

A. Oh, I'm sorry. I can't recall the exact dates. I think it was pre-pandemic.

Q. Dr. Brizuela's clinic was in Morgantown?

A. I believe so.

Q. And you also listed that you testified in another case, United States versus Brizuela and Naum, N-a-u-m, and you said that's a different case from the first case against Dr. Brizuela; is that right?

A. Yes.

Q. Okay. What was the difference between the cases?

A. One was a pain management -- Brizuela was operating as, I think, an independent practitioner, a clinic that was a pill mill. And as we've seen, a lot of the pill mills then moved away from prescription opioids into kind of pill mills with respect to medications for opioid use disorder,

specifically buprenorphine-based compounds.

And he was also involved in a pill mill that was distributing buprenorphine-based products, an addiction treatment clinic that was ultimately a pill mill.

Q. You testified in trial in the Brizuela and Naum case?

A. Yes.

Q. Did you give a deposition in that case? I assume not, but did you?

A. I don't believe so.

Q. Did this trial result in a conviction?

A. I believe so, but I can't recall exactly.

Q. And you've listed a third case, United States versus Naum, in the Northern District of West Virginia.

Was that also a criminal case?

A. I believe so.

Q. And you testified on behalf of the federal government?

A. Yes.

Q. Was this another pill mill case?

A. Yes, addiction treatment clinic.
Q. Is Naum a doctor, or was Naum a doctor?
A. Yes.
Q. Was your testimony in these three cases -- was the nature of your testimony in general the same, that these doctors were prescribing opioid medications improperly?
A. I believe so, whether it was prescription opioids for pain in the context of a pill mill not being legitimate or prescription medications -- prescription opioids for substance use disorder treatment in the context of a pill mill, not legitimate.
Q. Did your testimony in any of these three cases relate to in any way the pharmacy dispensing opioids? In other words, was the substance of your testimony related to a pharmacy dispensing opioids?
A. I don't believe so. It was focused more on the legitimacy of the orders issued by the practitioners with prescriptive authority.
Q. Okay. Was Dr. Naum convicted in

the third case?

A. I believe so, but can't recall specifics.

Q. The fourth case, Hatcher versus B&K Pharmacies, Inc., the Circuit Court of Mingo County, West Virginia, what was the nature of that case?

A. I have difficulty recalling specifics, but it, again, was associated with a pill mill.

Q. Who did you testify on behalf of in that case?

A. I can't recall the specifics at this point.

Q. Was that a criminal case?

A. I do not recall.

Q. When was that case?

A. Either -- I think it was before the pandemic at some point.

Q. Did you testify in a deposition?

A. Yes. So it was a deposition.

Q. Did you ever testify in a trial?

A. No.

Q. Were you testifying on behalf of

the pharmacy in that case or against the pharmacy?

A. I do not recall the specifics. I was -- I rendered opinions regarding, I think, with just the pill mill and the legitimacy of it and similar ...

Q. Similar to what?

A. I think prior -- prior work.

Q. Similar to the work in the Brizuela and Naum cases?

A. If I recall correctly, regarding kind of standards of practices regarding pain management, legitimacy of prescriptions, opioids, addiction.

Q. Was this a case where families of patients were suing the pharmacies for providing opioids to them?

A. I'm not sure. I apologize. I can't recall.

Q. Did you in the Hatcher versus B&k pharmacies case give any opinions about the standard of care applicable to pharmacies?

A. Not that I can recall, other than I think commenting on -- unless it was -- pill

mills are really criminal enterprises as opposed to clinical practices. And in order to maximize profits, a lot of prescriptions need to be written for and filled ultimately, and sometimes those pill mills grow to include pharmacies and interface with them in a manner to further the criminal enterprise.

Q. Did that case, the Hatcher case -- did your testimony in the Hatcher case involve you giving any opinions about the pharmacies themselves?

A. I can't recall.

Q. Who hired you in that case? Was it a law firm?

A. Yes.

Q. Do you remember the name of the law firm?

A. I think it was Legato & Cagle.

Q. Did that case ever go to trial?

A. I don't recall. I think it may have settled.

Q. Other than these four cases in the last four years, have you at any time given testimony as an expert by deposition or trial,

other than these four cases?

A. Not that I'm aware of.

Q. At any time -- I'm not limiting my question to the last four years.

At any time have you given testimony as an expert in deposition or trial other than these four cases?

A. I don't believe so.

Q. Have you ever given testimony that you recall here today regarding the obligations of pharmacies as it relates to filling opioid prescriptions?

A. I don't recall doing so.

Q. Have you given testimony either by deposition or at trial at any time regarding the role of the federal government in regulating the opioids industry?

A. I don't believe so.

Q. Have you ever given testimony either by deposition or at trial regarding your opinions about the gateway theory related to prescription opioids and illicit drugs?

A. I do not believe so.

Q. Have you ever given testimony in

any deposition or trial regarding the responsibility of community pharmacies for the crisis of addiction?

A. I don't recall doing so.

Q. Has your testimony ever been successfully excluded from any court proceeding?

A. Can you define -- I'm not sure if I understand what that would mean.

Q. Yeah. That's probably a legal term.

Sometimes in court proceedings, one side will challenge whether an expert should be permitted to give testimony in a trial.

Has that ever -- has anybody ever challenged your ability to give testimony in any of the four trials you've been -- or four cases you've been involved in?

A. I think, if I recall correctly, that occurred in the context of maybe -- that was part of -- I think they did -- yeah, I'm sorry. I don't -- I don't understand all the legal terms and kind of that process, but I know that came up as a question when I was testifying. And I think then they let me move

forward with that.

Q. You've anticipated my next question, which is do you know whether those challenges were successful?

A. I don't believe they were.

Q. Other than the four cases where you've provided testimony either at trial or in a deposition, have you ever written a report for litigation but then were not asked to give either deposition or trial testimony?

A. I believe that's occurred in --

Q. On how many occasions has that occurred?

A. Well, I think some of it depends on who was kind of making the initial request for work.

So I think with the cases that -- the cases with the federal government, they initially are kind of brought forward or the connecting link, as we discussed earlier, is with the investigators at the DEA.

So I'd say roughly half of the cases brought to me regarding kind of prescribing practices have led -- you see what's

up here now. Probably the other half didn't really lead to any -- you know, didn't move forward to formal report preparation and/or testimony.

Q. How about in any civil cases? Have you ever written a report and then did not give either deposition or trial testimony?

A. I don't believe so. The other work I think listed on my CV, I've worked for the Board of Medicine in kind of more administrative board actions that didn't progress to that point.

And then I also consulted with the Maryland Attorney General's Office in another case that never progressed due to, I think, federal prosecution kind of occurring.

Q. Did you give a report or write a report in that case?

A. No, I don't believe I did.

Q. Have you ever testified before Congress?

A. No.

Q. Have you ever given testimony before a grand jury?

A. I don't believe so.

- - -

(Marshalek Deposition Exhibit 7 marked.)

- - -

BY MR. CHALOS:

Q. Let's mark as the next numbered exhibit tab 1, which is your curriculum vitae.

MR. CHALOS: This will be, what, Exhibit 6?

TRIAL TECH: 7.

MR. CHALOS: 7.

BY MR. CHALOS:

Q. Okay. Exhibit 7 will be your curriculum vitae, which is tab 1 of your notebook.

Tell me when you have that in front of you, Doctor.

A. I do.

Q. Is everything listed in Exhibit 7, your curriculum vitae, accurate?

A. To the best of my knowledge.

Q. Is it current?

A. I believe so.

Q. Let's walk through this.

Your education, you got your Bachelor of Science at the West Virginia University in May of 2020 [sic]; is that right?

A. Yes.

Q. And then you started medical school shortly thereafter in July of 2020 [sic] at WVU as well?

A. Yes.

Q. The general psychiatry training, is that the residency you did in psychiatry?

A. That is correct.

Q. What made you decide to go into psychiatry?

A. That's a good question.

I always tell people I would have laughed if you told me when I started out in med school I was going to go into psychiatry. But I think it's -- I had wonderful experience doing my clerkship and kind of understood the things that psychiatrists were able to diagnose and treat and had the most fun doing that. So that's the path I went down.

Q. Did you intend when you decided on psychiatry as a focus to get into addiction

medicine?

A. Well, yeah, I think addiction being part of -- part of psychiatry. I think that -- seeing that addiction was being approached as an illness and treated and being treated by psychiatrists and other allied health professionals was certainly a pull. Not the only pull, but a pull in the direction of psychiatry.

Q. Did you grow up in Morgantown?

A. Yes, I did.

Q. You saw, I assume through your adolescence and adulthood, that there's a real bad opioids problem in Morgantown?

MR. CARDI: Object to form.

A. I always pivot back and say, you know, it's an addiction problem. Yeah. Some of my -- if I look through a high school yearbook, I'll see some folks that aren't here anymore and for a variety -- you know, alcohol, opioids, other drugs.

Q. You got your medical license in 2007?

A. Yes.

Q. And it's listed here that you have a certification that says ABPN. What does that mean?

A. That's the American Board of Psychiatry and Neurology. That's the governing -- that's the board that allows me to -- allowed me to seek and receive a certification in psychiatry.

Q. I see.

And you got that in January of 2012 for psychiatry?

A. Yes. That certification process entailed sitting for and passing a written exam, and then going forward and doing an oral portion of the board as well.

Q. Did you pass the boards on your first attempt?

A. Yes.

Q. You also have an ISN-ECT certification. What is that?

A. That was a certification that ISN, the International Society for Neuro -- modulation or simulation. I apologize because they've changed their name maybe since I

received that initially.

Looking at some of the neuromodulation, which would entail electroconvulsive therapy or ECT, transcranial magnetic stimulation or TMS.

Q. Do you administer ECT as part of your practice?

A. Yes, yes. A big part of my practice is also focusing on advancing therapies for patients suffering from treatment resistant mood disorders.

Q. Do you use ECT as an addiction treatment?

A. I mean, that's a good question. I think -- you know, addiction I think doesn't discriminate. It oftentimes doesn't live alone, so there are other comorbidities that will live near it, chicken or egg, not always kind of known clearly at the time what came first.

But, yes, I've taken care of patients that have had serious alcohol use disorders. The alcohol was fueling a depression and also kind of medicating it, and the patient really wouldn't get better until we treated

their depression kind of aggressively with ECT. And then that led to less relapses on alcohol because they were feeling better, if that makes sense.

Q. You've also received a board certification in addiction medicine?

A. That is correct.

Q. Did you pass those boards on your first attempt?

A. Yes, I did.

Q. All right. You were an assistant professor at WVU School of Medicine between July 2010 and June of 2017; is that right?

A. That's correct.

Q. Okay. What did you teach? What courses did you teach?

A. I can't recall the courses I taught. I think -- our academic rank is the basis of kind of clinical, academic, and other scholarly output.

Q. Was that a full-time job?

A. Yes.

Q. And then you were promoted to associate professor in July of 2017?

A. That's correct.

Q. You held that job until February 2022 when you left briefly to work in Portland, Oregon; is that right?

A. That's correct. Yes.

Q. Did you continue teaching at WVU that spring of 2022?

A. Yes. That's why I was -- that's why I think as I transitioned away, I retained a clinical adjunct in order to do so.

Q. What courses did you teach during that time?

A. I can't recall if there were any active courses or didactics that I needed to present at that -- during that kind of brief time period.

Q. Then you came back full time as an associate professor in June of 2022?

A. Correct.

Q. What does it mean to be the addiction division section chief which you've done from September 2022 to present?

A. We have a large group of allied health professionals that treat patients with

substance use disorders. It's a division that encompasses routine ambulatory treatment of those conditions. And then all the way from there to, you know, hospital-based treatment of folks presenting in the emergency department and/or to the clinical floor with a host of things and everything in between, including residential treatment.

So it's leading kind of a large group that are working in a variety of clinical settings and making sure that they have -- that we grow it, that they're supported, that we're adhering to the current standards, and so on.

Q. Do you also have a clinical practice currently?

A. Yes.

Q. And that's at the Chestnut Ridge Center, or is it in addition to that?

A. Well, my practice current -- I currently am -- the assignment I have is running our consultation liaison service and emergency psych services. I'm filling in for a provider who is out.

Q. Who is "we" in that sentence?

A. I'm sorry. I can't remember when I said "we."

Q. Okay. All right. Let me ask you -- fair enough.

You said the assignment you have is running -- I'm sorry -- our consultation liaison service. Is that WVU's?

A. Yes. My academic appointment is through WVU, the academic institution. The health system is also who's paying me to see patients.

The patients I'm seeing currently are in either Ruby Memorial Hospital floor emergency department, primarily. That's the clinical area I'm covering due to the provider that covers that -- those service lines is out.

And that includes general academic consultation liaison service. That includes a substance use -- dedicated substance use disorder team that I helped build and grow, and some grant-funded emergency psych services to system EDs.

Q. What was that very last part?

A. Grant-funded emergency psychiatry

services to system EDs.

Q. EDs being emergency departments?

A. Emergency departments.

Q. What is the Chestnut Ridge Center?

A. It's where my office is. It's a -- the upstairs is acute inpatient psych. The downstairs is ambulatory. It's just one of many centers that are kind of housing various service lines that our department and health system has.

Q. Is that part of the WVU network?

A. Yes. I kind of chuckle briefly only because at one point in time -- and I'm the last person to probably comment -- it was a private institution owned by the Ramsey Corporation that then, through the years, funneled into the health system, and it's now part of it, albeit a standalone, not directly connected to the hospital.

Q. Standalone physically you mean?

A. Yeah. Yeah. It's like this little two-story building that's -- yeah.

Q. What is the William R. Sharpe, Jr. Hospital?

A. That's one of our state hospitals.

Q. And you're currently on staff there as a psychiatrist?

A. No. I was when I first came back due to -- based on my prior administrative and clinical experience and acute inpatient psych and kind of medical directorship, that institution right as I was coming back was in transition. They were transitioning from one medical director to another. And we were also on-boarding a couple new faculty that I had trained previously.

So I was asked, as I came back, to kind of go down there and help with some of those transitions. I'm no longer down there now.

Q. I see.

When did you stop your work with the Sharpe Hospital?

A. I think it -- I might have listed it. Hold on. Let me see. Did I list it?

Q. It says through present.

A. Oh, that's -- that might be a typo. I think it was about -- somewhere between August and September I transitioned away from

there. That would need to be updated.
I apologize.

Q. Okay. Was your work at Cascadia Behavioral Healthcare -- was that related to addiction treatment?

A. Yeah. That was the pull-out there that -- it was a certified community behavioral health center that recently received FQHC lookalike status. So a big part of my career had been trying to develop and deploy new programming.

So this was a wonderful opportunity to kind of continue to do so as the combination of the FQHC and the certified community mental health center would allow us to deploy some novel programming for kind of whole health, kind of collaborative or multidisciplinary care.

So it was myself as the senior psych leadership alongside an internal medicine physician, senior medical leadership, and the plan was to work together.

Q. You said in your report in your background that you assisted with the successful

launch of the WVU Medicine Center for Integrative Pain Management.

What is that?

A. We expanded our pain clinic to be -- become much larger and much more comprehensive. I was called upon to lend my expertise with respect to psychiatry, pain management, and addiction to help grow that, to be able to tackle, you know, any number of cases that would present there.

Q. Is that still in operation?

A. Yes, it is.

Q. Do you have any involvement with it presently?

A. Indirectly just based on my role as the addiction division section chief now.

Q. Going back to your CV, Exhibit Number 7, the section "Invited Lectures and Presentations." It's on pages 6, 7, 8, and most of 9. The last one listed here, the most recent one listed, is May of 2021, "TMS for Depression."

Have you given any lectures or presentations since May of 2021?

A. Yeah. I think I gave -- I need to update that. I gave one in September.

Q. What was that about?

A. On psychedelics and psychiatry. It was an update of a talk I've given over the years.

Q. What's the nature of that talk?

A. Just giving kind of some historical context regarding medication -- you know, what are psychedelics, and then kind of fast-forwarding to some of what's going on now regarding kind of ketamine for treatment-resistant depression, MDA for treatment-resistant PTSD, and psilocybin for other treatment-resistant conditions.

Q. Are there any invited lectures or presentations that you've given that are not listed on pages 6, 7, 8, and 9 of your curriculum vitae?

A. I don't believe so. I hope this is accurate and just needs to be updated to reflect the last presentation we just discussed.

Q. All right. Starting on page 9 through pages 10, and most of page 11, your

publications are listed.

First of all, is this all accurate?

A. I believe it is. I believe this was everything in press currently.

Q. All right. Are there any articles that you have -- that have been published that you were involved with as an author or researcher that are not listed here?

A. Not that I can recall.

Q. Have you submitted any articles for publication that were rejected?

A. I believe so.

Q. Did any of those relate to opioids in any way?

A. I can't recall the exact projects. Many of the -- I'd want to know how you're defining "rejection." A lot of times things aren't accepted upon initial submission and require, you know, some degree of revisions, as I'm sure you're aware. So I can't recall if anything never kind of -- never really failed to get published.

Q. Okay. You've listed your book

chapters starting on page 11 of Exhibit 7, and it looks like there are two book chapters that you've authored; is that right?

A. I believe so.

Q. Have you authored any other book chapters other than the ones listed here?

A. I don't believe so.

Q. All right. Editorial, you've listed yourself as the associate editor of the Frontiers in Public Health: Substance Use Disorder and Behavioral Addictions.

Do you see that?

A. Yes.

Q. It looks like there might be a typo in "addictions" there for when you're revising your resumé next.

Who publishes Frontiers in Public Health?

A. I don't recall. Sorry.

Q. Is it a medical organization? Do you have any idea?

A. I'm not -- I can't recall off the top of my head if they're connected to a broader-based something.

Q. Okay. Are you paid for your work as the associate editor?

A. No.

Q. All right. You're also an ad hoc reviewer for the Journal of Groups in Addiction and Recovery; is that right?

A. Yes.

Q. Who publishes that journal?

A. I'm sorry. I'm not able to recall.

Q. You're also an ad hoc reviewer for the Journal of Human Lactation. Is that still true?

A. I believe so.

Q. Do you know who publishes the Journal of Human Lactation?

A. I'm sorry. I do not recall.

Q. And as an ad hoc reviewer for both of those journals, you are called upon periodically to review submissions for publication; is that right?

A. That's accurate.

Q. All right. Let's look here at your expert consultation. We'll get through

this, and we'll take a lunch break.

You list here that West Virginia Board of Medicine, you've assisted the board with multiple cases against physicians; is that right?

A. Yes.

Q. Did any of your work with the West Virginia Board of Medicine involve you giving testimony in a hearing?

A. I don't believe it did.

Q. Have any of the matters that you've consulted with the West Virginia Board of Medicine involved pharmacy practices?

A. I don't recall.

Q. With respect to the Department of Justice, Drug Enforcement Administration, United States Attorney's Office, you said in that section three cases went to trial and testimony provided.

Those are the cases we described earlier against Dr. Brizuela and Naum; is that right?

A. Yes.

Q. You said here that you've written

reports -- or written reports are submitted when indicated/requested.

Did you do written reports in cases other than the three listed on your CV?

A. I don't believe so.

Q. All right. Maryland Attorney General, we talked about that earlier. You consulted regarding the Insys Therapeutics matter; is that right?

A. Correct.

Q. And that never resulted in any report or testimony; is that correct?

A. That's correct.

Q. And then this is the Mingo County case that you've listed here, and that is the case we discussed earlier, Hatcher versus B&K Pharmacies; is that right?

A. I believe so.

Q. Where you provided a deposition giving opinions about the prescribing practices of, I assume, physicians; is that right?

A. And legitimacy of those prescriptions.

Q. And I may have asked this, but did

your work in the Mingo County case involve you giving any opinions about pharmacy dispensing?

A. I don't believe so, unless it was related to kind of the connection of a pharmacy to a pill mill to further the criminal enterprise.

MR. CHALOS: I see. Okay. Why don't we break here and take lunch.

THE COURT REPORTER: We are off the record at 12:27 p.m.

- - -

(Thereupon, at 12:27 p.m. a luncheon recess was taken until 1:03 p.m.)

- - -

Monday Afternoon Session
January 9, 2023
1:03 p.m.

- - -

THE COURT REPORTER: We are back on the record at 1:03 p.m.

BY MR. CHALOS:

Q. All right. Let's look, Doctor, at Exhibit 1, which is your report. And I'd like to focus your attention on the last -- well, it's page 5, the last -- second to last paragraph on page 5. It starts with "Far upstream."

And I'm looking primarily at that first sentence. You can take as much time as you need to review the paragraph or the whole document.

A. I see it.

Q. Okay. So the sentence that you wrote says, "Far upstream from the busy prescriber, pharmacist, and community pharmacy sat those with power and ability to limit the overall amount of prescriptions that ultimately contributed to the epidemic of overdose deaths."

Do you see that sentence?

A. Yes.

Q. The footnote 23 that you cite there, if you turn to page 12 of your report, Exhibit Number 1, is the Stanford-Lancet Commission publication.

Do you see that?

A. Yes.

- - -

(Marshalek Deposition Exhibit 8 marked.)

- - -

BY MR. CHALOS:

Q. And if you turn to tab 10 of your notebook, you'll find, I believe, the document that you referenced in footnote 23 of your report as support for that sentence we just read.

Do you see that?

A. Yes.

Q. Is this the Stanford-Lancet Commission report that you intended to cite in footnote 23 of your report?

A. I believe so.

Q. Where in this document do you find support for the sentence, "Far upstream from the

busy prescriber, pharmacist, and community pharmacy sat those with the power and ability to limit the overall amount of prescriptions that ultimately contributed to the epidemic of overdose deaths"?

A. Your question again? I'm sorry. I was looking --

Q. Yeah. The question is, where in that report, what we've marked as Exhibit Number 8, the Stanford-Lancet Commission report -- where in there do you find the support for that sentence you wrote in your report?

A. I'd have to -- I need a little time to figure -- this is a longer article. I haven't read it since I kind of prepared for the report.

I mean, I think one -- it's -- part of it's bulleted in the key messages, the second key message, with respect to just regulation where they expand upon kind of the regulatory.

I think that's -- my statement is kind of highlighting the clinical situations that I'm familiar with where patients are coming

in and out. Prescriptions for more than just opioids are moving, you know, out of the office into pharmacies, and kind of how far downstream that is.

You know, it's like if opioids are raining, and there was rain, you know, far upstream of that, the rain could have been stopped by specifically the federal government, whether it's with respect to overall amounts of opioids kind of being issued each year or various programs that could kind of either improve education, maximize the benefits, or minimize some of the risks.

Q. Pharmacies played a role in the oversupply of opioids into communities, right?

MR. CARDI: Object to form.

A. Yeah, I don't know what role you mean.

Q. All right. Well, let's look at page 12 of the Stanford-Lancet Commission report. Let's take a look at what they found.

Page 12, there's a section that says, "Domain 1."

Do you see that?

And there's a quote from Patrick Radden Keefe's book, Empire of Pain. It says the, "The opioid crisis is, among other things, a parable about the awesome capability of private industry to subvert public institutions."

Do you see that?

A. Yes.

Q. Do you agree with that sentence?

A. I do with respect to what we've come to know about private industry's role in this epidemic.

Q. If you look then -- the bottom of the second full paragraph under that section, it's actually on the upper right of the page. It says "and profit-seeking" is the sentence, the last sentence of that paragraph.

MR. CHALOS: You had it right, Jon, the first time. It's on the top right after those superscripts. It says "and profit-seeking."

TRIAL TECH: Oh, I see it.

BY MR. CHALOS:

Q. Okay. It says, "And

profit-seeking was not entirely external to the health care system. Some hospitals, clinics, pharmacies, professional societies, and individual healthcare professionals also enriched themselves."

Do you see that?

A. Yes.

Q. So the Stanford-Lancet Commission concluded that at least some pharmacies played a role in contributing to the opioid crisis, right?

A. I think I've stated that before. I think the pill mills and those -- some of the other things connected to pill mills, those are clinical settings. Those are driven where -- those are criminal enterprises, not legitimate clinical settings.

I think that's the -- they've done a tremendous amount of damage based on the fact that they kind of took their understanding of how health care was delivered and manipulated it in order to only seek profit and no other kind of legal or ethical considerations.

Q. And some pharmacies, some

community pharmacies, not connected with pill mills also contributed to the opioid crisis by filling prescriptions that shouldn't have been filled, right?

MR. CARDI: Object to form.

A. I don't know if I agree with that based on what we talked about before. Pharmacies -- unless you present me with kind of direct evidence of pharmacies kind of focusing solely on profit margins and otherwise kind of more closely aligned with a kind of criminal enterprise than a clinical enterprise, they're still not in a position to question the legitimacy of those prescriptions. That's an incredibly challenging thing to do.

Q. It's your opinion that pharmacies are not in a position to question the legitimacy of opioids prescriptions?

A. I'm just not sure how they can. They weren't in the doctor's office where it was being written. They don't know if it was just handed to that person by an office staff, you know, that was just using a stack of scripts that had kind of the same prescriptions stamped

on them, or if it was a legitimate pain management practice that was doing their best to take good care of the patient.

Q. So it's your belief that pharmacies have no tools to use to determine whether a prescription was written for a legitimate medical purpose?

MR. CARDI: Object to form.

A. Like I said, I think they're at a distinct disadvantage to question and to kind of call that into question. To the extent that they increasingly call that into question poses other kind of unintended consequences and risks related to kind of delays and delivery of much needed care potentially and so on.

Q. So it's your view that pharmacies should not question the legitimacy of an opioids prescription?

MR. CARDI: Object to form.

A. I just don't know -- sorry.

MR. CARDI: You can proceed.

Object to form.

A. I just don't know how they can since they weren't in the office where the

patient was being diagnosed and treated and that recommendation sprang forth.

The list of potential explanations ranges from, you know, extremely legitimate to not, and how they can begin to step into and investigate that and whether they should is a whole other --

Q. And that belief that you just set forth is one of the bases for your opinions in this case?

A. I'd want to make sure I understood kind of exactly what I said and how I said it. The fact that this, the highlighted sentence, I mean -- I've taken care of patients that sought to enrich themselves.

So I've witnessed anyone from a patient, prescriber, pharmacy, pharmacist, upwards on that chain all the way up to the manufacturer take steps to enrich themselves in a variety of ways.

And oftentimes those steps involved deceptive practices making it much harder to determine how legitimate it is because it's like a Trojan horse in some ways.

Q. One of the bases for your opinions in this case is the belief that pharmacies are not in a position to question whether an opioids prescription is written for a legitimate medical purpose; is that correct?

A. I believe so.

Q. Who is Dr. Judith Feinberg?

A. Dr. Feinberg, if I understand correctly, is on faculty at WVU, an infectious disease specialist.

Q. She's a professor of behavioral medicine and psychiatry at WVU?

A. She's an infectious disease specialist who has -- is a part of our department based on her work.

Q. Okay. And that's your department, right, the department of behavioral medicine and psychiatry?

A. Yes.

Q. She's in your department?

A. Her appointment is in our -- she has an appointment in our department I think similar to my appointment being in anesthesia based on my pain experience, even though I'm not

an anesthesiologist.

Q. Okay. And she's the vice chair for research in the department of medicine at WVU?

A. I don't know if that is accurate at this time.

Q. All right. You know her personally, right?

A. I know her. I have chatted with her before, I think. Not I think. I have chatted with her. I don't interact with her on a very regular basis, though.

Q. Do you have any view of her professional competence?

A. I'm not -- she's an infectious disease specialist. I'm not --

MR. CHALOS: Okay. What exhibit are we up to? Is it 9?

MR. CARDI: I believe the next exhibit would be 9. Yes.

MR. CHALOS: Let's mark as Exhibit 9 the document that we sent over the lunch break. It's the ASPPH document dated November 2019 "Bringing

Science to Bear on Opioids."

- - -

(Marshalek Deposition Exhibit 9 marked.)

- - -

BY MR. CHALOS:

Q. Are you familiar with the Association of Schools and Programs of Public Health, Doctor?

A. I don't believe so.

Q. Okay. I'll represent to you that if you -- well, let's look at it. Let's go to the very last page of the document.

And you'll see in the bottom right corner that the West Virginia University School of Public Health is a member institution of the ASPPH. It's a little bit further up. Yeah, there it is.

Do you see that?

A. Yes.

Q. And if you go to page 35 of this document, you'll see that Dr. Judith Feinberg is listed as a member of the task force.

Do you see that?

A. Yes.

Q. And if you look -- let's go to page 38.

If you look at the last sentence under Dr. Feinberg's bio there, it says, "As professor of behavioral medicine and psychiatry and professor of medicine/infectious diseases, she is working hard to turn the tide on opioid misuse and opioid-related epidemics."

Do you see that?

A. Yes.

Q. Okay. Have you worked professionally with Dr. Feinberg in any of the opioid-related issues?

A. Her being an infectious disease specialist and my kind of -- my specializations, we cross paths with a really complex and acute subpopulation that suffers from addiction, and those tend to be patients that have progressed to using IV drugs. And once you start using IV drugs, like I said, the complexity and acuity increases above and beyond what you would normally expect.

So we interface in terms of how do we take care of patients suffering from

infective endocarditis related to injection drug use or a whole host of other relatively nasty, for lack of a better term, infectious complications from those that progressed injecting drugs into their bloodstream, not just opioids.

Q. Let's look at page 8. This is within the introduction of this document.

Well, let me back up. Let's go up to page 3, the Executive Summary.

The second bullet point, the task force cites here a sentence that says, "On average, 130 Americans die each day from an opioid overdose." And they cite to the CDC document for that.

Do you see that?

A. Yes.

Q. Do you know if that's accurate?

A. Well, I hope if it's being put forth in here, but I can't tell with certainty.

Q. All right. Do you have any reason to dispute that?

A. I don't.

Q. All right. And the bullet point

above that says, "More Americans die each year from overdose" -- sorry. Let me redo that.

"More Americans die each year from opioid overdoses than died in any armed conflict since the end of World War II."

Do you see that?

A. Yes.

Q. And they cite the National Academies of Science, Engineering and Medicine report for that.

Any reason to dispute that?

A. No.

Q. Let's turn over to page 8 in their introduction to the task force's report here.

If you look at the last paragraph, the second sentence. The task force that included Dr. Feinberg from your department concluded, "The tremendous expansion of the supply of powerful (high-potency as well as long-acting) prescription opioids led to scaled increases in prescription opioid dependence, and the transition of many to illicit opioids, including fentanyl and its analogs, which have subsequently driven exponential increases in

overdose."

Do you see that?

A. Yes.

Q. Do you dispute that sentence, sir?

A. I don't know if I would phrase it that way. Again, it's what we talked about before. These things correlated.

Now, whether it caused the kind of increase in OUD or kind of increased overdoses, that's a different story. So I think I'd be careful how I phrased it, and I would not phrase it that exact way.

Q. Okay. So you take issue with their use of the word "led" where they say the "expansion of supply of powerful prescription opioids led to scaled increases in prescription opioid dependence and the transition of many to illicit opioids"?

A. Yeah, I don't know if I agree with how that's phrased and what it states.

Q. What would you say then, sir?

A. I would say some of what we said before, because I think, you know what, the increased prescriptions were not all legitimate.

We talked about that. So it's not citing the role that -- it's making it seem like just regular pain management led to all these problems. And I just think there's a lot to unpack in that sentence.

Q. So you, looking at this document of this task force, included your colleague Dr. Feinberg and -- I don't know -- a dozen or so other distinguished physicians and scholars, you think they're wrong when they said that the tremendous expansion of supply of powerful opioids led to increase in prescription opioid dependence and the transition of many to illicit opioids?

MR. CARDI: Object to form.

A. I'm not saying -- I can't even remember what the question was at that point. I'm sorry.

Q. You're saying they're wrong.

A. I'm saying I don't agree with how they're saying what they're saying and the sentence being taken out of context. I doubt I'd disagree with every single thing in here.

In fact, you know, some of what

they're talking about, I'm a big proponent of prevention. I'm a big proponent of anti-stigma. I think some of these statements taken out of context can actually contribute stigma to kind of opioids and opioid use disorder in general, and also kind of pain management with opioids.

Q. And you're basing that, sir, on your clinical experience, right?

A. In part.

Q. You're not basing that on any studies that you've done, are you?

MR. CARDI: Object to form.

A. I just citied some of what -- I cited that I agreed with some of these recommendations here. Maybe what's behind it and what context some of these other words are utilized in -- because I think that the qualitative -- you know, if you ask me qualitatively to evaluate that, say yeah, this is a problem, I think I agree with them in that sense. Yes.

But no one's going to sit here, including myself, and say, yeah, there aren't a lot of overdoses or, no, that's not a problem.

How we got to that point, I think there are a lot of different ways to look at that and state them.

Q. Are you basing that opinion on any studies that you have done?

A. I'm basing it on my education, training, clinical experience, and kind of continual evaluation of the evidence base, you know, how we got to where we got and formed my opinion of that, which is not in lockstep with that. I think that's also something that's risky in some of these situations kind of adhering to group think potentially.

I would cite that as a reason why we kind of got into some of these problems in the first place with pushing too hard to treat pain and who was pushing, where, when, and how, and why.

Again, I think there's a lot to unpack in that sentence, and it could be interpreted in a variety of ways, you know, looking at something as simple as the tremendous expansion of the supply and what was behind that, you know, so how we got to that point.

Q. Do you agree that the tremendous expansion of the supply of powerful prescription opioids, however we got there, led to scaled increases in prescription opioid dependence and the transition of many to illicit opioids?

A. I don't know if I -- I struggle with how that's -- how that -- everything they're trying to pack into that sentence. So I don't think I would say it that way. I don't think I agree with it.

Q. You think they might be subject to group think?

A. I wouldn't go that far. I just worry about situations where that can occur.

Q. Do you consider your opinions in this case to be outside of the mainstream?

MR. CARDI: Object to form.

A. I would not believe so.

Q. Do you think your opinions are in the mainstream?

A. I honestly don't -- I'm not sure how I'd answer that.

Q. Do you think you're potentially subject to group think?

A. I think anybody is.

MR. CARDI: Object to form.

Q. How about the opinions you've expressed in this case? Let's go back to your report, Exhibit Number 1.

You say -- I'm on page 3 of Exhibit Number 1 -- "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to use of illicit drugs, is unsubstantiated and controversial"?

You do not cite to a single source for that sentence, do you, sir?

MR. CARDI: Object to form.

A. I think we discussed how that was cited and the basis for that opinion.

Q. Okay. Answer my question, please.

A. Can you ask it again, please.

Q. Sure.

Do you cite to a single source, any source, to support your sentence on page 3 of Exhibit Number 1, "The 'gateway' theory, which proposes that the use of prescription opioids directly leads to use of illicit drugs, is unsubstantiated and controversial."

Do you cite to a single source to support that sentence?

MR. CARDI: Objection; asked and answered.

A. Yeah, I believe I answered that earlier.

Q. Answer it again, please, Doctor.

A. The fact that there's not been -- causality hasn't been proven, so to advance a theory forward to suggest that somebody that's exposed to opioids is now like they're exposed to some sort of communicable disease is now going to develop it and kind of to view that as a pathogen despite knowing how complex and all the other kind of aspects of addiction that we know and all the things that we don't know, I don't think that's fair.

Q. Okay. With all due respect, Doctor, you didn't answer my question.

My question is this: Did you cite to a single source to support that sentence?

A. Yes.

MR. CARDI: Objection; asked and answered. We discussed this for

15 minutes at the beginning of this deposition.

Q. And the single source you cite to is the Miller article; is that right?

A. We discussed citing the Miller article, as well as my -- the basis for my opinion being connected to my education, training, clinical experience, and practice.

Q. And you believe that your theory in that sentence is in the mainstream of the epidemiological community?

MR. CARDI: Objection; mischaracterizes his prior testimony.

A. I don't believe I'm alone in criticizing this theory or hypothesis based on the fact that causality has failed to be established.

Q. But you didn't cite anyone else who criticizes the theory that prescription opioid exposure leads to the use of illicit drugs?

MR. CARDI: Object to form.

A. Again, the basis for that article and multiple other articles led into that

article which led into those articles and so on, so ...

Q. I'm not sure if I understand what you mean by that. What other articles?

A. Well, we looked at 14. We looked at all the articles that 14 cited, anything that substantiate -- when they talk about causality not being there, they cite that, and it's based on that.

So there's a body of evidence. I'm not alone in feeling that the causality is an important part that has yet to be established for that.

Q. Well, let's look at that article, then. Let's look at the Miller article.

A. What tab is that? I'm sorry.

Q. That is tab number 5 in your notebook.

MR. CHALOS: And what is this exhibit number? Jon, do you know, offhand? I didn't write it.

TRIAL TECH: Exhibit 2.

BY MR. CHALOS:

Q. All right. So let's look at

Exhibit 2, which is tab 5 in your notebook.

And you said, "Let's look at all the articles that were cited in the Miller article," and let's look at those.

So there are exactly six articles cited as references in the Miller article. The first one is titled "Paternal alcohol exposure and hyperactivity in rat offspring: Effects of amphetamine."

Do you see that?

A. Yes.

Q. The second article is "Genetic influences on adolescent behavior."

The third article is "Prior exposure to alcohol has no effect on cocaine self-administration and relapse in rats: Evidence from a rat model that does not support the gateway hypothesis."

The next article says, "Sex differences and longstanding consequences of adolescent ethanol exposure for the rewarding effects of cocaine in mice."

The next article, "Consequences of adolescent use of alcohol and other drugs: Study

using rodent models."

And the last article is "Epigenetic effects of cannabis exposure."

Do you see that?

A. Yes.

Q. Have you read any of those articles?

A. I don't recall if I've read any of these articles.

Q. Well, which articles in this list support your theory that the gateway theory related to prescription opioids and illicit drugs is unsubstantiated?

A. What we discussed before, simply the fact that this is still referred to as a theory or a hypothesis, and that much of what has been written about this is -- will cite, readily cite, that the causality has not been established.

Q. All right. Doctor, you didn't answer my question.

My question is, which of those six articles support your theory that the gateway theory related to prescription opioids and

illicit drugs is unsubstantiated? Which of those six is my question.

A. I'm not sure which of those six. I'd have to read through all six of them.

Q. But you haven't done that, have you?

MR. CARDI: Objection; mischaracterizes prior testimony.

A. I don't recall if I've read all of those articles.

Q. Do you recall reading any of the articles?

A. Which articles? The referenced articles?

Q. Yes, sir.

A. I just do not recall if I've read any of those articles.

Q. Okay. So as we sit here today, other than what you believe the Miller article to be, what other articles can you point us to that support your theory that the gateway theory related to prescription opioids and illicit drugs is unsubstantiated? Can you point us to a single other article other than Miller that you

believe supports that sentence?

A. I'd have to go back into it and do a review of the literature in order to answer that question.

Q. Can you cite, as we sit here today, a single article other than Miller that you believe supports your theory about gateway?

A. I can't recall, as we sit here, specific articles.

Q. Did you do that literature search before you submitted your report to a federal district court in this case?

MR. CARDI: Objection; asked and answered.

A. I think we talked about that earlier. Throughout my career, I spent a lot of time in medical journals seeking to better understand current evidence bases and have read articles on a wide variety of topics, many of which I can't recall the exact nature of.

It's possible I've read previous articles that have touched on that in the past. I just can't recall as we sit here.

Q. You spent 99 hours writing this

report, sir?

MR. CARDI: Object to form.

A. I believe we discussed that earlier. I think that's correct.

Q. I don't think you discussed that with me.

In that 99 hours, you didn't find one article beyond Miller that you believe supports your theory about gateway and opioids; is that right?

MR. CARDI: Object to form.

A. Can you ask me that question again, please.

Q. Sure.

In the 99 hours you spent working on this case, you did not find one single article beyond the Miller article that you believe supports your gateway theory?

MR. CARDI: Object to form.

A. I believe this article best substantiated my opinion. And that's why I chose it.

Q. Okay. Let's look at tab 18 of your notebook. We'll mark that as the next

numbered exhibit, and I have lost track.

MR. CHALOS: What is the next number?

TRIAL TECH: This will be 10, Exhibit 10.

- - -

(Marshalek Deposition Exhibit 10 marked.)

- - -

BY MR. CHALOS:

Q. Okay. Exhibit 10 is three pages of invoice -- it looks like three separate invoices. One is directed to Publix. One is directed to Albertsons. One is directed to Kroger.

Do you see that, sir?

A. Oh, right there. Okay.

Q. It's on the screen. It also should be tab 18 in your notebook.

A. Oh, I'm sorry. I was looking -- it must have been 17.

Yeah, I see that. I apologize.

Q. Does this three pages -- is this the entirety of your invoices to date in this case?

A. To date, yes.

Q. And you were, I guess, at some point retained to work on behalf of Albertsons, Publix, and Kroger?

A. That's a question? Did you --

Q. Yes. Oh, I'm sorry. Yes. Question mark at the end of that.

Were you at some point retained to work on behalf of Albertsons, Publix, and Kroger?

A. I believe so. I can't recall specifics.

Q. It looks like these -- the invoice was for a total of 99 hours at $400 per hour for a total amount of $39,600, which is then, as it says here in the invoice, one-third portion attributed each to Publix, Albertsons, and Kroger; is that correct?

A. That's what I see before me.

Q. Did you prepare these invoices?

A. I submitted my hours in a generic invoice. I think this was -- this was prepared -- I can't recall exactly how this was prepared.

Q. Who did you submit your invoice to?

A. I can't recall the exact person I sent it to at this moment.

Q. Was it somebody at a law firm?

A. It might have been Aaron Boone.

Q. Who is Aaron Boone?

A. Aaron works for Bowles Rice.

Q. And you think after that, somebody divided the invoice into three parts.

A. I don't exactly recall how and why that's split up.

Q. Is 99 hours a correct number of hours that you spent to date in this litigation?

MR. CARDI: Object to form.

A. That's the time period stated on the invoice. That's the amount of time spent.

Q. Is that correct?

A. Within that time period, to the best of my knowledge.

Q. And the time period reflected in the invoice is November 16, 2022 through December 16, 2022, right?

A. Yes.

Q. And is that accurate?
A. I believe it is.
Q. Did you do work in this litigation prior to November 16, 2022?
A. I don't recall doing any work before then.
Q. Were you contacted shortly before November 16, 2022 to do work in this case?
A. I don't recall the exact dates.
Q. Was it about that time that you were contacted?
A. I honestly don't recall.
Q. Do you have anywhere a breakout of what you spent your time doing for those 99 hours?
A. I don't recall breaking that down or having a breakout.
Q. The invoice that you submitted to counsel, did it include more detail than just working with counsel in preparing the Track 7 report?
A. I can't recall exactly what it -- what it had in it.
Q. Do you have that invoice still?

A. Did we look at it earlier?
I can't recall if we did.
Q. No, sir. Not with me.
Do you still have that invoice?
A. I don't recall where it is.
Q. How did you send that to counsel?
By e-mail?
A. I believe so.
MR. CHALOS: We ask that you produce the invoice. And this is directed to Mr. Cardi; that you produce the invoice that Dr. Marshalek sent to counsel. If it's different in any way or if it's just a different document from the one we have here, we ask that you produce that.
BY MR. CHALOS:
Q. Dr. Marshalek, did you keep your hours in a notebook or a calendar in some way in connection with your work in this case?
A. In a notebook.
Q. Did you write a description of the work that you did for those hours in your notebook?

A. If I recall correctly, I may have.
Q. Don't throw that notebook away, please, Doctor.
Do you still have it?
A. No.
Q. What did you do with it?
A. I believe I have shredded it with any other kind of documents that would be connected to this other than what we have here.
Q. What documents did you shred?
A. Just notes and I think kind of some of the initial engagement paperwork that was sent onward.
Q. Why did you shred documents?
A. That's common practice when I'm doing clinical work, writing notes. A lot of it's protected health information or confidential.
Q. I'm sorry. What protected health information was at issue in this case?
A. Well, that's just my -- that's common with my clinical practice, to kind of have paperwork and/or notes or documentation containing protected health information or other

confidential topics.

Q. You shredded in this case your notes that you created in connection with your work here?

A. Well, my notes moved into my report, and I had no use for them after that. And I think based on some of the engagement stuff, if I recall correctly, some aspects of this is confidential. So that was my way of securing it.

Q. Did somebody tell you to shred documents?

A. No. That's just my common practice with -- if not, I would be overrun with an office full of confidential and/or protected health information.

Q. Did anybody tell you that you need to keep your documents related to your work in this litigation?

A. I don't recall.

Q. You don't recall if anybody ever told you that?

A. I don't.

Q. Did you have any discussions with

anybody about whether you should shred documents in connection with your work in this litigation?

A. I don't recall.

Q. And you also believe that you shredded your notebook where you kept a log of the work that you did and the hours you spent doing that work?

A. Once submitted, I tend to get -- once it's in electronic format, there's no need to hold anything behind, at least in my opinion. So that's what's behind that practice.

Q. Okay. But I'm asking you a question.

You shredded the notebook where you kept a log of the work that you did and the hours you spent doing that work?

A. I believe so.

Q. Did you include in what you submitted to counsel a description of the work that you did and the time you spent doing that work?

A. I'm sorry. Can you repeat that?

Q. Sure.

Did you include in the invoice you

submitted to counsel a description of the work that you did and the time you spent doing that work?

A. I believe so.

Q. What else did you shred, sir?

A. I can't recall. I think just the stuff that I felt I had no need for and that was just cluttering or already kind of -- already made its way into electronic format and passed along.

MR. CHALOS: All right. Let's take a break. Let's take ten minutes.

THE COURT REPORTER: We are off the record at 1:47 p.m.

(Recess taken.)

THE COURT REPORTER: We are back on the record at 2:00 p.m.

MR. CHALOS: Doctor, I have no further questions at this time.

MR. CARDI: Okay. I have no questions.

MR. CHALOS: All right. You're free to go.

THE WITNESS: Thank you.

(Signature reserved.)

- - -

Thereupon, at 2:00 p.m., on Monday, January 9, 2023, the deposition was concluded.

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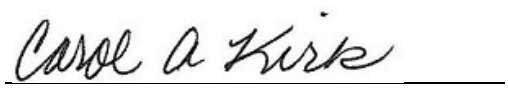
CERTIFICATION

I, Carol A. Kirk, Registered Merit Reporter and Certified Shorthand Reporter, do hereby certify that prior to the commencement of the examination, PATRICK J. MARSHALEK, M.D., was duly remotely sworn by me to testify to the truth, the whole truth, and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by me at the time, place, and on the date hereinbefore set forth, to the best of my ability.

I DO FURTHER CERTIFY that I am neither a relative nor an employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.



Carol A. Kirk, RMR, CSR
Notary Public

DEPOSITION ERRATA SHEET

Case Caption: National Prescription Opioid Litigation
Case Track 7

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

_____
PATRICK J. MARSHALEK, M.D.

SUBSCRIBED AND SWORN TO
before me this _____ day
of _____, A.D. 20___

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Notary Public

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